Lither Marie Goins 04-02387 crn 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 7, 2004 **Physician** 8:38 A.M Marie Esther Goins /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner mary s 9. Birthplace (State or Foreign Hollywood

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 23949 Mervell Dean Road 8. Date of Birth (Month, Day, Ye, Sept. 12, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 2^{Year)}1951 Country) Maryland Months 1 □ M 2√□ F 52 Yrs. 217-60-5483 **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f ehow any injury or other traumatic event, the Marical Examines man be notified at 1 ☐ Yes 2☐ No St. Mary's Maryland Hollywood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Baltimore, Maryland 21215-0036

Physician /Medical Examine

within 24 hours after death

To the Funerel Director: / Ce Medical

29a. Certifier

29b. Signature and title of certifie

Theodore M King

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

<u>ea</u>	23949 Mervell Dean	Road	20636	5	Uni	ted States					
ner		 Was Decedent Ever in U.S. Armed Forces? 	13. Was Decedent of I	Hispanic Origin? (Speci pan, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.					
Ē	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐No	1 ☐ Yes 2 No		Jul., 5151,						
þ	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	1 Li Yes 24 No	<i>Specny</i> :		Specify: White					
Completed by Funeral	15. Decedent's Educ (Specify only highest grade	completed)	6a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	16b.	Kind of Business/Industry					
mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	,	Ov	n Home					
Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maide	en Sumame)					
မ	Marino Marini			Marion Be	AND DESCRIPTION OF THE PARTY OF						
	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailing Address (Stree	t and Number or Rural	Route Number, City	or Town, Stete, Zip Code)					
	Sean M. Goins/ Son	P	.O.Box 1504,	Leonardtow	m, Maryla	and 20650					
	20a. Method of Disposition		e of Disposition (Name of etery, crematory or other pla	Da	te 20c.	Location - City or Town, State					
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		es Memorial	Gdns 4-12-		nardtown, Maryland					
	21. Signature of Funeral Service Dicense	M01114				neral Home, P.A. itown, Md 20650-0279					
	23a. Part1. Enter the disease, or official shock, or leart failure. List only on	cations that caused the death. I	o not enter the mode of dy	ing, such as cardiac or	respiratory arrest	Approximate					
	Immediate Cause (Final disease or condition	Cocaine suba	racanola nemo	orrnage seco	ondary to	ruptured Onset and Death mmunicating artery					
	resulting in death)	Due to (or as a consequen		tor the an	terior co	minum cating artery					
		,									
100	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):								
-Fu	cause. Enter Underlying Cause (Disease or injury										
Examiner	that initiated events c resulting in death) Last	Due to (or as a consequen	Due to (or as a consequence of):								
	il III.										
by Physician/Medical											
Š	IF FEMALE:										
2	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		CV		23d. Date of delivery Month Day Year					
3	in the past 12 months?	4☐Pregnant at time of deat				Month Day Year					
Jys.	1 Yes 2 No 9 Unknown	9□ Unknown									
P	Part II. Other significant conditions con	tributing to death but not resulting	ng in the underlying cause g	iven in Part I.	23e. Did tobacc	o use contribute to the cause of death?					
	I.				1 Tes	2 No 3 Probably 4√√XUnknown					
tec											
Completed					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
6					performed′ ty⊟ Yes 2 ☐ !						
(a)	25. Was case referred to medical			26. Place of Death	Δ-						
To B	examiner?	lospital: 1 ☐ Inpatient 2 ☐ EP	VOutpatient 3□ DOA O			6 Other (Specify)at scene					
	27. Manner of Death	28a Date of Injury 28	3b. Time of 28c. Inju		Bd. Describe how in						
6	1 □Natural 5 □ Pending	(Month, Day Year)	Injury W	unknown							
ertification:	2 Accident investigation 3 Suicide 6X Could not be	The state of the s	ILI O.S.CI								
E	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, tarm, street, factory, office	office 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Ser		found in resider	nce	. 2	3949 Mervel	rvell Dean Rd., Hollywood, N					

Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

O.C.M.E.

besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated.

29d. Date signed (Month, Day, Year)

April 08, 2004

21201

State Registrar

Penn Street, Baltimore, Maryland

DRORIPPLE FOR

ed cause of death (Item 23a) (Type, Print)

32. Projistrar's Signature

			for State Registrar	State of Maryla	•	artment of F			iene g. No. 200	4 13002
4	Physici /Medic	cal	Decedent's Name (First, Middle, Las Anna Velma As Facility Name (If not institution, give	Hat	ley	4b. City. Town. o	r Location of Deat		Day Year 29, 2004	8:45 PM
	Examir Funeral Director	ier	Crofton Convaleso 5. Social Security Number 6. Se	ent Center	s. last birthday) Yrs.	Croft	on	. 8. Date of Birth	Anne Aru	
	the Maryland r 28a-f show	tor	10a. State 10b. County Maryland Anne Aru		City, Town or Lo	crofton				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
9500-91212	hours after death witt tural', or Items 23a o al Exeminet mual be	eted by Funeral Director	10e. Street and Number 2131 Davidsonvill 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grav	12. Was Decedent Ever in Armed Forces? 1	16a. Dece	10f. Zip Code 21114 Was Decedent of H If Yes, specify Cuba 1 Yes 2 No dent's Usual Decup	Specify: ation during most of wo	Specify Yes or No- to Rican, etc.)	0g. Citizen of What C U. 1 14. Race - Am Black, Wh Specify: 16b. Kind of Busines.	S.A. Bencan Indian, ite, etc. White
	I be filed within 72 ntal Hygiene. ed other than "nal event, tre Medic	Be Completed	Elementary/Secondary (0-12) 12 th 17. Father's Name (First, Middle, Last) Albert L. Tol	College (1-4or5+)		DO NOT use retired Clerk	18. Mother's Na	me (First, Middle, 1	•	ernment
, Maryland	and 2 should laith and Mer 27 is marko er traumatic	10	19a. Informant's Name/Relationship (7 Bruce Hately(ype, Print) Son)	378	Langford	and Number or A	ural Route Number	City or Town, State, ryland 20	
Baltimore,	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service License	Ma	ryland	osition (Name of matory or other place Veterans 2. Name and Addre 6633 016	Cem. 20	004 ee Funera	l Home ,	n. Maryland
/60,	Physician /Medical Examiner, the printer transit transit the printer transit trans	Ilcal Examiner	23a. Pant. Enter the disease or compshock, or heart failure. List only of instance or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.	equence of): entication			-		Approximate Interval Between Onset and Death Jeans jeans
.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	23c. If yes, outcome of preging 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of de Month	Blivery Day Year
7	The law requires that the te has been signed by th vage 2 should be detache	by	Part II. Other significant conditions co	ontributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	1	to the cause of death?
		Completed	OF W.						y prior to ned? death? No 1 Ye	utopsy findings available completion of cause of
ō	il or Attanding Physician: after death. Diractor: After this certific in by the funeral director.	Certification; To Be	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injun Worl M 1	er: 4 Vursing h	28d. Describe ho	e) nnce 6	
S O	4	al Certif	4 ☐ Homicide determined 29a. Certifier f Certifying Phy	28e. Place of Injury - At building, etc. (Spec	cify) nowledge, deat	h occurred at the tin	ne, date and place	City or Town	n, State) ause(s) and manner a	s stated.
	To the Hospital or a within 24 hours after To the Funaral Dirac completely filled in b	Medical	(Check only one) 2 Medical Exam 29b. Signature and title of certifier	iner: On the basis of examinand manner stated.	M ()	29c. Licens		2	ate and place, and du 9d. Date signed (Mon	
4	RIA		30. Name and address of person who co			Print)				/ /
	Sta Registr		Rakesh Arora, MD 31. Date filed (Month, Day, Year) APR 0 1 2	32. Pygistrar's Sigr	nature	pode	ZZZ, BO	wie,Maryl	and 20/15	

for 1_ State		State of Marylan	-	rtment of I			giene Reg. No 2004	13003
Registrar 1. Decedent's Nam	e (First, Middle, Last)		Oei	incate of	Death	2. Date of Dea	ath	3. Time of Death
Physician		ucille	Нс	ouchin		Month March 2	Day Year 8. 2004	6:05 P
/Medical Examiner 4a. Facility Name (f not institution, give st	reet and number)		4b. City, Town, o	or Location of D		4c. County of Dealt	
	m Nursing	Home		Fort Was				George's
Funeral 5. Social Security N	umber 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Ain. (Month, Day	h 9. Birth	place (State or Foreign intry) t Virginia
Director 232 20 6		M 347 84	ris.			Jan 20	b, 1920 wes	t virginia
	10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
Maryland	Prince (George's Fo	ort Was	hington_				1 Tes 2 No
10e. Street and Nu				10f. Zip Code			10g. Citizen of What Co	•
E 2 = E	Raymond Co		0 40.1	Was Davidson of	20744		United S	
9 E 11. Marital Status	ied 2 Married	 Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No 	j			? (Specify Yes or No- uerto Rican, etc.)	Black, White	
hours aff		1 □ Yes 2 □ No If Yes, Give XX Year or Dates:		□ Yes 2¶\No	Specify:		Specify: Wh:	ite
Complete by Milking 12 12-12-10-12 of within 72 hours at 12 12-12-12 of of within 72 hours at 25 of	15. Decedent's Educatify only highest grade		(Give	lent's Usual Occu kind of work done	during most of	working	16b. Kind of Business/l	ndustry
Ord Strain of Special Control of		College (1-4or 5+)	life. I	00 NOT use retire .retary	ed)		Lega1	
N Section 12 17. Father's Name	(First, Middle, Last)	2	Dec	- Ctary	18. Mother's	Name (First, Middle,		
C SES D Hanks	rt L. Cork				A1ma	Talkingt	on	
	ame/Relationship (Typ	e, Print)	19b. Mailin	g Address (Stree	t and Number o	r Rural Route Numbe	er, City or Town, State, 2	ip Code)
_ 5 % W =	. Drews, I						ington, MD	
Ψ ーエるき 20a. Method of Dis		emoval from State	Place of Dispo cemetery, cren	sition (Name of natory or other pla	3Ce)	Date	20c. Location - City or	Town, State
Solution 1 ☐ Burial 2 1 ☐ Burial 2 1 ☐ Donation 21. Signature of F	Y Y Y Y Y Y Y Y Y Y						Clinton, M	
21. Signature of F	ineral Service License		10	. Name and Addr			al Home,Inc	
23a, Part I, Enter	he disease, or complic	ations that caused the deat					inton, Marl	Approximate
shock, or hea	irt failure. List only one (Final	e cause on each line.	1		nen			Interval Between Onset and Death
Physician disease or condition resulting in death)	on a.	Due to (or as a conseq	uence of):	n for	i se			27.106
Examiner Sequentially list of	anditions b.	Hyp	a par	allerva	den			1m
Sequentially list of a rank, leading to the cause. Enter Und	nmediate erlying	Clue to (or es & conseq	uerice of):	a Bra	0			1111
Example 2 of that initiated event resulting in death)	S C.	Due to (or as a conse	ence of):	accer				170
ar prince par Que		740	Det	home	200	_		in
				1	2000			
N To See See See See See See See See See Se	nt pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	су		23d. Date of deli Month	very Day Year
ysicial in the past 12 1	□No	4☐Pregnant at time of d 9☐Unknown		Other (specify)	·		World	Day 10a
D at the dot of the the by S S Part II Dther sign		tributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did t	bacco use contribute to	the cause of death?
w requires it w requires it should be d should be d placed by		•		, ,		1 12	r Yes 2 □No 3 □ Pr	obably 4 Unknown
w requirements should be an all the should be an all the should be a should be			_			24a. Was	an 24b. Were au	topsy findings available
TYITAI RECORD TYSICION: The law requirements to sentificate has been so idirector, page 2 should director, page 2 should a case retermined. To Be Completed.						— autor perfo 1 ☐ Yes	ormed death?	completion of cause of
	rred to medical				26. Place of	Death (Check only o		
ois a direct of Doc	INO		ER/Outpatier	nt 3 L DOA	_		dence 6 Other (Spec	cify)
27. May fer of Dea	5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	We	uryat ork? ⊒Yes 2 ∐No		how injury occurred	
Lor Attending Physicien: The law requires t after death. Director: After this certificate has been signed by the funeral director, page 2 should be ertification: To Be Completed by ertification: To Be Completed by Howing a special page 2 should be ertification: To Be Completed by ertification:	investigation 6 Could not be	28e. Place of Injury - At h	ome, farm, sti			28f. Location (S	Street and Number or Ru	ral Route Number,
Division 2. Washer of Dec 3. Washer of Dec 4. Washer of Dec 5. Safet of Castline of The	determined	building, etc. (Special	fy)			City or Tox	wn, State)	
dsortifier 29a. Certifier (Check only	1XXCertifying Phys 2 Medical Examin	ician: To the best of my knower: On the basis of examina	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date and popinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
one) To the that of the company one) To the company one) To the company one) To the company one) To the company one)	title of pertifier	and manner stated.		29c. Licer	nse number		29d. Date signed (Monti	n, Day, Year)
F 3 F 0	121	W2		D-	2453	55	03.29.0	04
30. Name and add	iress of person who con	mpleted cause of death (Iter	m 23a) (Type,	Print)				
		700 Old Bran	ch Ave	#101, C	linton,	Maryland	20735	
State 31. Date filed (Mo	APR 0 1 2	32. Re strar's Sign.	ature	Soule				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 27, 2004 **Physician** 12:05 PM JOHN DUDLEY HANSON, SR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner LA PLATA CHARLES GENESIS HEALTH CARE CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Feb. 6, 1925 9. Birthplace (State or Foreign Country)
Mary land 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Yrs. 79 Director 219-16-0841 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylen Dapartment of Health and Mentel Hygiene.
Important: If item 27 is merked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at pice. 1 □ Yes 🕻 □ No Pomfret Directo Maryland Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20675 4435 Columbia Park Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. ☐ Yes 2X☐ No Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specity: δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Sanders Thomas Bayard Hanson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4435 Columbia Park, Pomfret, MD 20675 Marjorie L. Hanson - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 D Burial 2 Cremation 3 Removal from State St. Joseph's Ch. Cemetery 3-30-04 Pomfret, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01391 20604 HUNTT FUNERAL HOME, P.O.BOX 156, WALDORF, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** ANCHEATE CANCEN. Immediate Cause (Final disease or condition resulting in death) /Medical K MONDY Examiner Examine physician end s the buriel-transit Hospital or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medicai Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No eral Diractor: After thi filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide within 24 hours after d To the Funeral Diract completely filled in by 4 ☐ Homicide edicai 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 29, 2004 30. Name and addless of person who completed cause of death (Item 23e) (1) pe. Print)

DHMH 16 Rev 6/95

State

Registrar

GEORGE H.

31. Date filed (Month, Day, Year)

MD,

32. Projetrar's Signature

WATHEN,

MAR 3 0 2004

11345 PEMBROOKE SQ., #103, WALDORF, MARYLAND 20603

			i icas	State of Manda	nd / Don	artment of L	Libert A	Acetal Hygi	ne Legible.	
			For State Registrar	State of Maryla	па / Dep <i>Се</i>	artment of H	ieaith and iv Death	ientai Hygii	ene 200L	13005
			Decedent's Name (First, Middle,	Last)				2. Date of Death	-	3. Time of Death
	Physici		Wanda Ly	nn McClung	Hic	cks		Month April	8 2004	1:45 a M
	/Medic Examin		4a. Facility Name (If not institution,				Location of Death		4c. County of Dea	
			Calvert Memoria	l Hospital		Prince 1	Frederick		Calvert	
	Funeral			5. Sex 7. Age (in yrs		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign
	Director		430-56-2249	^{1□M 2} F 72	Yrs.			Aug 16,	1931 Ar	kansas
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	f sho	ō	MD Anne	Arundel		Deale	0			1 ☐ Yes 2 ☑ No
	28a	Director	10e. Street and Number	ALUIQEI		10f. Zip Code	E	10	g. Citizen of What C	ountry?
	3a or		5907 Alexander	Tane		2075	1		USA	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Ame	
9	or Ite	교	1 ☐ Never Married 2X Marrie	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	Hican, etc.)	Black, Whi	ie, etc.
ဗ္ဗ	arel',	d by	3 Widowed 4 Divorced	Year or Dates:			Specify.		Specify: V	<i>i</i> hite
5-	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or items 23a or 28a-f ehow event, the Madical Exertires mast be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	/Give	edent's Usual Occupa a kind of work done o DO NOT use retired	durina most of work	ing 1	6b. Kind of Business	/Industry
12	withir ane. than	ф	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	_	ucator	"		omirroto in	nitromai bu
2	filed Hygi Sther ant, I		17. Father's Name (First, Middle, La		<u> </u>	ucator	18. Mother's Name	e (First, Middle, Ma	orivate u aiden Sumame)	iiversity
Maryland 21215-0036	lid be lental ked ked	To Be	Ocie J.	McClung			Floy	Alma	Atchlev	
ary	should and Men s marks umatic		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mail	ing Address (Street a			City or Town, State,	Zip Code)
	and 2 ealth a n 27 is		Doin E. Hicks,		Box	178, 5907	Alexande	r Lane,	Deale, MD	20751
ore	of He		20a. Method of Disposition 1		Place of Disp cemetery, cre	osition (Name of matory or other place	(e)	Date 26	Oc. Location - City or	Town, State
altimore,	Pages Iment of I tent: If its jury or o	٠,	*4 □ Donation 5 □ Other (Spe	ecify) Ne		e Cemetery		2-2004	Sheridan,	Arkansas
Bail	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Items 23a or 28a-f ehow any injury or other treumatic event, the Modical Extending man be notified at once.		21. Signature of Funeral Service Li	censes 91		2. Name and Addres	,		0.1	
	40280		220 Barti Enter the disease or o	omplications that bayend the des	th. Do not on	ausch Fund	eral Home	P.A.,	Owings, 1	AD 20736 Approximate
			23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final	nly one cause on each line.	un. Do not en	ner the mode of dyin	g, such as cardiac	or respiratory arres	ι,	Interval Between Onset and Death
	Pnysician /Medical	e In	disease or condition resulting in death)	a. Pneumonia Due to (or as a conse	guaras afti					Days
n	Examiner			Upper Airw		truction				Days
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		<u></u>				24/2
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Right Para		geal Mass				1 Month
760,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conse	•		C	C-11	O	4 37
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	leath certificat attending phy I for use as the	lan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy				23d. Date of de	livery
Вох	death a atte	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		□Ectopic pregnancy □ Other (s <i>pecify)</i>			Month	Day Year
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S, D	The law requires that the death certifica tie has been signed by the attending ph age 2 should be detached for use as th	by P	Part II. Other significant condition	s contributing to death but not re	sulting in the t	anderlying cause give	en in Part I.			the cause of death?
ord	w require been sij should b		Parkinsonism					1 🗆 Yes	2 X No 3 □ P	obably 4 Unknown
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Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	7	-t old Box Othe	0.00	h (Check only one)		
ō	Phys r this sral di	\vdash	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of Injury	28b. Time of	of 28c. Injury	4 □ Nursing Ho	me 5 ☐ Residen 28d. Describe how	ce 6 Other (Spe	cify)
On	Attending I r death. ector: After by the funer	tior	1 Natural 5 Pending 2 Accident investiga	(Month, Day Year)	Injury	Work	<br Yes 2 □No		,,	
Division of	or Attendation death Director:	ifica	3 Suicide 6 Could no 4 Homicide determin			reet, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
<u> </u>	itel or rs afte el Dir	Certification:		building, etc. (Spec.				Only 01 101111,		
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by		(Check only 2 Medical E	Physician: To the best of my kn xaminer: On the basis of examin	owledge, dea	th occurred at the time	ne, date and place, pinion, death occurr	and due to the cau	se(s) and manner as	s stated. to the cause(s)
	To the within 2. To the Complet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License			I. Date signed (Mont	
	F 3 F 8		Con 1/2	P. Sterner	m.A			230	April 8,	
			30. Name and address of person w							
	2		Gerald Sterner	. M.D. 19 Ch	esapeal	ke Beach F	Rd., E.,	Owinas. N	ID 20736	
	Sta	-	31. Date filed (Month, Day Year)	0 9 2004	ature	1 .0				
	Registr	ar	חות	CUU4 Jales	as St.	Goodes				

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2004 April 12, 7:25 p Virginia Hebert Ruth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick If Under 24 Hrs. 8 Calvert Memorial Hospital Calvert Prince If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months 1□ M 3√5√F 80 Maryland Director 212-20-6761 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 📆 No Directo Maryland Calvert Prince Frederick 10g. Citizen of What Country? 10e. Street and Number 23a or 1084 Adelina Road 20678 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ā Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours atter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2√√2 No Specify: Specify: white ģ 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) secretary suburan propane 11 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth any injury or other traumatic event 2008. Be Fowler Virginia Preston William Margie Hutchins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5930 Ray Norwood Rd., Prince Frederick MD 20
20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Ruth Ann Burggraff, daughter 20678 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remoyal from State
4 ☐ Donation 5 ☐ Other (Specify) Apr. 16,2004 Barstow, MD Asbury Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. s Island Rd. Port Republic , Ap M ... 20676 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Darkinson years Cevere /Medical Due to (or as a consequence of). Examiner injustive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for an a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Completed by Physician/Medical attending physic for use as the b 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav 5 Other (specify) 1 ☐ Yes 2 ₽No been signed by the a should be detached t o 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 100 Division of Vital 26. Place of Death Check onli one To Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Department 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) Atter thi funeral of 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide 1 (Livertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 60390 April 13, 2004 , MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 HUSPITAL Prince Adeeb Jaber 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of Ma	ıryland		irtment <i>tificate</i>			Mental F	lygien Rag. N	20	04	13	nn.
		Decedent's Name (First, Middle, Last)							2. Date of		Va.		3. Time of D	eath
Physicia	n	Elvin Bow	en H	lowa:	rd				April	4	2004	ar	6:15	a ^M
/Medica Examine	_	4a. Fecility Name (If not institution, give s	street and number)			4b. City, T	Town, or l	ocation of De		4	c. County of D	eath		
Examine		301 Russell Aven		1277	-	Gai	ther	sburg			Montgo	mery	J	
Funeral		5. Social Security Number 6. Sex	7. Age		ast birthday)	If Under Months		If Under 24 H Hours M		Birth Day Yea			ce (State or i	Foreign
Director		213-38-0469]M 20€7 95	5	Yrs.	Months	Days	Hours IVI	Apr 1	5, 1		ryl		
D	-	Usual Residence of Decedent		10- 0:5	r. Town or Lo							100	d. Inside City	Limits
uylar show	.	10a. State 10b. County										100	1t∑ Yes 2	
e Ma 3a-f s	cto	MD Montgomer	У	Ga	ithers					10- (N			
or 24	Dire	10e. Street and Number				10f. Zip	Code			10g. C	Citizen of What		yr	
ath w	Funeral Director	301 Russell Avenu						20877	/0	No	USA 14. Race - A		n Indian	
le de la companya de	nue	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. V	Was Deced f Yes, spec	ent of His ify Cuban	, Mexican, Pu	(Specify Yes or erto Rican, etc.)	NO.	Black, V			
s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	10	1	I□Yes 2	X No	Specify:			Specify:	whit	-0	
filed within 72 hours after death with the Maryland Hygiene. Hygiene the "natural", or Items 23a or 28a-1 show out, the Medical Examinat must be notified at	o o	15. Decedent's Edu			16a, Deced	ient's Usua	I Occupat	tion		16b.	Kind of Busine			
n 72	Completed	(Specify only highest grad	e completed)		(Give	kind of wor DO NOT us	k done di	ring most of v	working				•	
with than	E	Elementary/Secondary (0-12)	College (1-4or 5	+)	SC	hool	teac	her		r	oublic	sch	∞ l	
filed Hygi ther nt, I	Ö	17. Father's Name (First, Middle, Last)							Name (First, Mid	dle, Maid	en Sumame)			
d be antal	To B	Edward Lee Bowe	'n					Cora				Par	rdoe	
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Important: If frem 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	F	19a. Informant's Name/Relationship (T)			19b. Mailin	ng Address	(Street a		Rural Route Nu	mber, City	or Town, Stat	te, Zip C	Code)	
id 2 s ith ar 27 is trau	i		ghter		305A	Cros	s Gr	een St	., Gait	hers	ourq, M	ID 20	0878	
1 and 1 Health tem 27 Sther tr	-	20a. Method of Disposition		20b. P	lace of Dispo	sition (Nam	ne of	1	Date		Location - City			
Pages nent of I int: If its		1 M Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)		1		-		Cem. 4	1.704	Po	rt Repu	ıhli	C MD	
iit. P intensition	Ì	21. Signature of Funeral Service Licens		CIII		. Name and			1-7-0-1	FO	I C Nept	штт	.C, 11D	
permit. Departing Imports any injure.		11,000 Z	Ten		1111				me, P.A	I	ort Re	dua	lic, M	ID .
		23a. Part1. Enter the disease, or complete	ications that caused	the death									Approximate	
×		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lir	10.									Interval Betw Onset and Di	eath
Physician /Medical		disease or condition resulting in death)	. Cerebro			Accide	ent						days_	
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led sit	Examiner	Cause (Disease or injury	Atheros			Ioart	Dico	250				1	vears	
xecul and	xan	that initiated events resulting in death) Last	Due to (or as			learc	DISC	ase					years_	
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wrequires that the death been signed by the attershould be detached for		Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the u	nderlying c	ause give	n in Part I.	23e. D	id tobacc	o use contribu	te to the	cause of de	ath?
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TO 0 0	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury	M	8c. Injury Work	? ∕es 2 □ No	200. 2000	100 11011	ijary oddariod			
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or At fler of direct	rtiti	4 Homicide determined	28e. Place of Inj building, et	c. (Specif	fy)	reet, ractory	, onice			Town, St		or riurar	riodio ridina	
DIVISION To the Hospitel or Attending within 24 house after death. To the Funerel Director: After completely filled in by the fun		00- C-47 47-0 - 17-1	roleien, T- 45 - 5 - 1	of my lee-	udedes de	h 000	at the tier	a data and -1	lane, and due to	the cours	(s) and mane	ar as etc	nted	
Hos 24 ho Fune Fune	edical	29a. Certifier 157 Certifying Phy (Check only 2 Medical Exam	iner: On the basis o	f examina	ation and/or in	vestigation	, in my op	oinion, death o	occurred at the til	me, date	and place, and	due to	the cause(s)	
thin 2 the mple	Med	29b. Signature and title of certifier	and manner sta	a. 		290	. License	number		29d.	Date signed (M	Aonth, D	ay, Year)	
T Will		200. Signature and title of Certifier	1.7			1	D-333				4/4/04		,	
		1/20/01	11000		1111)			JONAF	THA MAI	14 112	R			
AI.		30. Name and address of person who o		. / ′	/	Print) L	EE:	MA	200	15				
10		25) 50 WS CONS	20 Registr	rar's Signa	hery	114	<u> ΣΕ</u>	1111	ARC.	710				
Sta Registr		31. Date filed (Month, Day, Year) ADD 0 5 200	An D	L. J Gigit	The	1 3 B								

			For 1 State	State of Maryland	d / Dep		Health and	Mental Hy		200	1. 10	000
			Registrar 1. Decedent's Name (First, Middle, Last	<u> </u>		rimouto or	Dodin	2. Date of De	ath	Date of Contract o	3. Time o	1 Death
	Physicia /Medic		Joseph	Vernon	Hav	kins, S	Sr.	April		2004	8:35	5 A ^M
	Examin		4a. Fecility Name (If not institution, give	street and number)			or Location of Deat ince Fre			County of Deat	n vert	
			Social Security Number 6. S		last birthday							or Foreign
	Funeral Director		213-42-7563		O Yrs.	Months Days	Hours Min.	Apr. 1	2, 19	9. Birt Co 43 Ma	rylanc	1
yland	HOW I		10a. State 10b. County		y, Town or L						10d. Inside C	City Limits
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h with th	23e or 2	al Dire	10e. Street and Number 407 Rachel's	Way		10f. Zip Code 20	0678		TOG. CRIZ	en of What Co	ountry?	
deat	S S S S S S S S S S S S S S S S S S S	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	p- 1-	4. Race - Ame Black, Whit		
d 21215-0036 filed within 72 hours after death with the Maryland	al', or its	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1		1 ☐ Yes 2 🕅 No				Specify: B	lack	
5-0 72 Po	netur lical	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occu	pation during most of wo	rking	16b. Kin	d of Business/	/Industry	
21215-0036 9d within 72 hours aft	then the Max	omple	Elementary/Secondary (0-12)	College (1-4or 5+)		Laborer	ed)		Со	nstru	ction	
	other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	_	_		
/lar	Menta arked	To B	William Ler	roy Hawkin			Marth			ones		
Maryland od 2 should be file	7 is muttreaum		19a. Informant's Name/Relationship (7 Margaret Johnson	**			tand Number or Ad 's Way I		-			3678
. .	Heal tern 2 other		20a. Method of Disposition	20b. P	Place of Disp	osition (Name of ematory or other pla	ace)	Date	20c. Loc	cation - City or	Town, Stete	
MO Pages	ent of nt: If i ny or o		1 Mail Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Hamovai from State		. Garde:	1 .)/2004	Dunk	irk,	MD	
Baltimore,	Depariment of Health and Mental Hygiene. Importent: or Items 23a or 28e-f ehow importent: If item 27 is marked other then "natural", or Items 23a or 28e-f ehow any injury or other traumatic event, the Medical Exeminer must be invitible at once.		21. Signature of Funeral Service Licen	Sewell	12	2. Name and Addr	ess of Facility Se	ewell F	uner	al Ho e Fre	me d.,MD2	2067
E	hysician (Medical xaminer e priial-trausit	Examiner	23a. Part 1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, fram, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence) b. Due to (or as a consequence) c. Due to (or as a consequence)	uence of):	C(NOM)					Onset and	Dealii
Box 68760, eath certificate be executed	attending phy for use as th	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d. 23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di	ancy	□Ectopic pregnan:	су		2	3d. Date of de Month		Year
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COL	been	Completed			-			24a. Was		24b. Were a	utopsy findings	available
He He	page 2	фшо						auto perf	ormed? 2 No	death?	completion of	cause or
ital	certificate rector, pag	BeC	25. Was case referred to medical				26. Place of De	ath (Check only				
of Vita	Q 12.	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	ent 3 DOA	ther: 4 Nursing I	Home 5 Les	idence 6	Other (Spe	ecify)	
	fter		27. Menn of Death 1 I Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe	how injury	occurred		
Division	within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, s fy)			28f. Location City or To	(Street and wn, State)	1 Number or R	ural Route Nur	nber,
Hoepig	24 hours Funere etely fille	edical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.								(s)
, E	within To the	Me	29b. Signature and little of certifier			29c. Licer	nse number		29d. Date	signed (Mont	th, Day, Year)	
•	•		Fall	UNU		D	7324		4/6	1200	YC	
1	0		30 Name and address of person who	completed cause of death-(Hern		Cox R	the Har	Angt	rws	MD.	2043	5
	St	ate	31. Date filed (Month, Day, Year)	32. Registrats Signa	ature	South						J

			1 - For State Registrar		f Marylar		artmen rtificat			and M		Reg. N	ie io. 20	04	13009
Ч	Physici		1. Decedent's Name (First, Middle Katie W	le, Last) Ha11							2. Date of De Month March	D		Year	3. Time of Death 6:10 A M
	/Medic Examin		4a, Facility Name (If not institution	n, give street and nur	nber)		4b. City,	Town, or	Location o	of Death	march		c. County of	of Death	0.10 A
			Glade Valley Nu		ehab			ersv					Frede		
	Funeral Director		5. Social Security Number 227-01-7304	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. 92	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug. 1	а <i>у, Үөа</i>	1911	9. Birthp Court Vir	lace (State or Foreign etry) ginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							1	0d. Inside City Limits
	Many -1 sh	tor	Virginia		R	lichmon	d								1 ☐ Yes 2X No
	or 28c	Jirec	10e. Street and Number				10f. Zip	Code				10g. C	Citizen of W	hat Cour	itry?
	ath wi	ral	3938 Decatur St					3224					USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any riqury or other treumatic event, Ita Modical Evarial or must be trafficed at ADGE.	Completed by Funeral Directo	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried Armed Fo	2 □½ No ⁄e		Was Deced If Yes, spec 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spa n, Puerto	ecify Yes or No Rican, etc.)	o-	Black	- Amend , White, White	
Maryland 21215-0036	nin 72 hou in "natural Medical E	pleted	15. Deceder	nt's Education st grade completed)		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired,	ition <i>uri</i> ng most	t of work	ing	16b.	Kind of Bus	siness/Inc	dustry
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and	ld be filk ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, James	Wren					18. Mothe		e (First, Middle		en Sumame cris	9)	
Mary	12 shou h and M 7 is mar treumat	-	19a. Informant's Name/Relations Phyllis Dobyns				-				al Route Numb				Code)
Baltimore, I	of Health of Health litem 2,		20a. Method of Disposition		20b.	Place of Dispo					Date		Location - (wn, State
Ē	Page ment ent: It		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	Specify)	State	le Mem	orial	Par	k 3		2004		esterf		
Ball	permit Depart import any in	d d	21. Signature of Fundamental Vice	Licensee							uffer I ke, Fre				
	Physician /Medical Examiner		23a. Pent Enter the disease, a snock, or bear failure. List immediate Cause (Final disease or condition resulting in death)	a Pec	aused the dea ach line. pleal (or as a consec	VAScul		Dise		cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed in the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consec										
P.O. Box 68760,	the death certifi y the attending p tched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of €	at death 3	⊒Ectopic pr ⊒ Other (sp						23d. Date Mon		ory Day Year
	w requires that been signed to should be deta	by	Part II. Other significant conditi	ons contributing to de	eath but not res	sulting in the u	inderlying c	ause give	n in Part I.						e cause of death?
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/ita	Physicien: this certificatal director, I	Be	25. Was case referred to medica examiner?	Hospital:				Othe	-	of Death	(Check only o	on <i>e)</i>			
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O	Attending ir death. ector: Alter by the fune	ıtlon	1 Naturat 5 Pendir 2 Accident investi		of Injury th, Day Year)	Intury	М	Work	? ′es 2 □ t				,		
Division of	after dea Director	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At h	nome, farm, sti	reet, factory	, office			28f. Location (. City or To			r or Rura	l Route Number,
	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	edical C		ng Physician: To the Exeminer: On the ba and mann											
	To the Mithin To the	Me	29b. Signature and title of certifie)r	1/		290	: License	number			29d. D	ate signed	(Month,	Day, Year)
•			· Ula	warm	X		1)40	307	M.	0		3/18	2/0	4.
			30. Name and ad less of person		e of death (Ite	m 23a) (Type,	Print)			,	,			-	
			Dr. Eugene (Casagrande	1564 (legiştrar's Sign	Opossun	ntown	Pike	, Fre	eder:	ick, MD				
**	Sta Registi			2 2 2004	150		Local	Sed.							

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 6:15 P M 17 2004 March Haines /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) **Examiner** Frederick Northampton Manor Nursing Home Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 XM 2 ☐ F 4, Yrs March 1919 Maryland Director 213-16-1533 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "naturel", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be to mutified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Woodsboro 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number filed within 72 hours after death with 9832 Steiner Smith Road 21798 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 N Married 1 XYes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: If Yes, Give Year or Dates: WWII 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiene. Line Foreman 11 Sewing Factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fit ment of Health and Mental Hitant: If item 27 is marked oth William Eldridge Haines Edna Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce E. Haines / Wife 9832 Steiner Smith Road Woodsboro, Maryland 21798 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If ite any Injury or ot March 20, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation 5 □Other (Specify) Fairmont Cemetery Libertytown, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONEY ARTORY DISCOSS C'ORDUARY resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 Yes 2 No 9☐ Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 X No 3 Probably 4 Unknown PLOWING FAIWTZO 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 No certificate 1 Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 EP/Outpatient 3 DOA 1 Inpatient Certification: To SIL funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? After ospital c. 24 hours after des. ...neral Director: Alte Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) d manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title D32171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALKENESULUE MD Z1793 R. GOUGH Po 300 328 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 2 2 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2004 W. Hamilton 1 March 16, 3:40 P. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 Stoney Mine Court Thurmont Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 29, 1938 Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2XX Delaware Director 65 221-24-0905 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show the Medical Examiner must be notified at Thurmont 1 X Yes 2 No Frederick MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 USA #4 Stoney Mine Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Items 11. Marital Status 1 Tes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Religion Minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nancy Elizabeth Hudson Wright Cayler Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #4 Stoney Mine Court, Thurmont, MD 21788 Hubert L. Hamilton/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 3/17/2004 Frederick, MD Frederick Crematory 21. Signature of Funeral Service i 22. Name and Address of Facility Stauffer Funeral Home, PA 104 East Main St. Thurmont, MD 21788 10 23a. P Let the disease shock, or heart failure. I mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the cause on each line. Approximate Immediate Cause (Final METATATIC BREAST CANGER **Physician** MONTHS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 □Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 200 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient Medical Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 031761 ddress of person who completed cause of death (Item 23a) (Type, Print) 501 W. SEVENTH ST. FREDERICK MB O'CONNOR MD 32. Register's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

		ř	For State Registrar	State of Ma	-	partment <i>ertificate</i>				giene Reg. No. 2	004	1301
	Physici		1. Decedent's Name (First, Middle, Las	ט		ŀ	tarvey		2. Date of De		Yeer)4	3. Time of Death 10:20 PM
*	/Medic Examir		4a. Facility Name (If not institution, give JOHNS HOPKINS HO	SPITAL		BAL	own, or Location			4c. Count		
	Funeral Director		5. Social Security Number 6. Security Number 212-82-6358	x 7. Age XM 2□ F 43	(In yrs. last birthd: Yrs	Months	Year If Und Days Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da DEC 14	, 1960	9. Birthp Coun MARY	lace (State or Foreign try) LAND
	within 72 hours after death with the Maryland ene. than "naturel", or itema 23e or 28e-f show he Madical Examirer musi be notified at	Director	10a. State 10b. County MD GARRETT		10c. City, Town or OAKLAND							0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ath with t	ral Dir	3517 GORMAN ROAD				21550			10g. Citizen of US	SA	
980	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "naturel", or itema 23a or 28a-f show or other traumatic event. The Widdell Examinat must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S.	3. Was Decede If Yes, specif	nt of Hispanic (y Cuban, Mexic		cify Yes or No lican, etc.)	Specia	ce - Americ ck, White, fy: W	
Maryland 21215-0036	within 72 ho iene. than "natu ine Modical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12		(G life	cedent's Usual ve kind of work b. DO NOT use UCK DRI	done during m retired)	ost of workin	g	16b, Kind of B	usiness/ind	dustry
yland 2	2 should be filed and Mental Hyg 1s marked other raumatic event,	To Be C	17. Father's Name (First, Middle, Last) PAUL SHERMAN HA	RVEY	'			her's Name LDRED	(First, Middle,	, Maiden Sumai Bl	ne) ECKMAN	1
	and 2 sho lakh and 27 is mu er trauma		19a. Informant's Name/Relationship (7 PAUL HARVEY - FAT			ailing Address (7 GORMA				er, City or Town MD 21550		Code)
Baltimore,	Pages 1 and of He Int: If item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dis cemetery, of WHITE C	rematory or oth	er place)	Da 7 3/19		20c. Location	•	wn, Stete ARYLAND
Baltir	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licent	See		22. Name and	Address of Fac	ility	P.O.	BOX 243	3	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compands, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	balaninal consequence of):	Citost		as cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and for use as the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury	b. Condico Due to (or as a	consequence of):	7						2000 1CW
P.O. Box 68	that the death certifica led by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death	3 ⊟Ectopic preç 5 ⊟ Other (spec					te of delive	ry Day Year
	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cau	se given in Par	t I.	10			e cause of death? ably 4 DUnknown
of Vital Records,	The la ste has page 2	Completed							24a. Was autop perfo 1 - Yes	osy rmed?	prior to con death?	osy findings available appletion of cause of
on of Vita	Attending Physician: The death. ector: Atter this certificate by the funeral director, pag	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Shpatient 28a. Date of Injury (Month, Day)	28b Time			Nursing Hom		one) dence 6 🗆 Other)
Division	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injun- building, etc.	y - At home, farm, (Specify)	street, factory,	office	28	8f. Location (S City or Tou	Street and Numb vn, State)	er or Rural	Route Number,
	e Hospil 24 hour e Funera letely fills	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	sician: To the best of iner: On the basis of e and manner state	xamination and/or	ath occurred at investigation, in	the time, date my opinion, d	and place, areath occurred	nd due to the d d at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
)	To th Vithir To th	Me	29b. Signature and title of certifier				License numbe			29d. Date signe	,	**
	le		30. Name and a tress of person who o	ompleted cause of dea	ith (Item 23a) (Typ	e, Print)				March 1		
	Sta Registr		31. Date filed (Month, Day, Year)	7004 ▶	s Signature	101fc	DT/I F	15.1	timur	e, mir	, / = = =	21237

		For State Registrar	State of Maryland	d / Depa	artmei	nt of H		Mental	Hygien Reg. N	e 2001	130
Physicia /Medic		Decedent's Name (First, Middle, Last) Carl Edward Huts			4b Cib	Tours or	Location of Do	2. Date of Month	ch &	As 200	3. Time of Death
Examin	er	4a. Facility Name (If not institution, give s 117 W Bee Tree Rd	treet and number)		Hend	erson				Carolin	.e
Funeral Director		222-10-0143	7. Age (In yrs. In 75	ast birthday) Yrs.	Months	Days	If Under 24 Hi Hours Mi	8. Date of (Month	of Birth n, Day, Yea 30, 1	9. Birti 928 Dela	hplace (State or Fore untry) Ware
72 hours after death with the Maryland natural, or Items 23e or 28a-f show dical Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Caroline 10e. Street and Number		Town or Lo	on	p Code			100 (Citizen of What Co	10d. Inside City Lim 1 ☐ Yes 2 🏋
3a or 3		117 W. Bee Tree Ro	ad		101. 2	2164	40			S.A.	· · · · · · · · · · · · · · · · · · ·
within 72 hours after deeth with the Marylan jiene. Than "natural", or Items 23s or 28s-f show the Madical Examiner must be notified at	by Funeral		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deci If Yes, sp 1 Yes		ispanic Origin? In, Mexican, Pue Specify:	Specify Yes o	or No-	14. Race - Ame Black, White Specify: Wh	
in 72 hou n "natura Aedical E	Completed	15. Decedent's Edui (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usi kind of w DO NOT	ork done o	during most of w	orking	16b.	Kind of Business/	Industry
e filed within at Hygiene. other than "	e Com	Elementary/Secondary (0-12) 07 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	mech	anic		18. Mother's N	ame (First, Mi		tomobile en Sumame)	
or should be life th and Mental Hyg 7 is marked othe traumatic event,	To Be	Carl Edward Hutson	Sr			İ	Mary Al	Lta Sew	ard		
death certificate be executed to the second of the second	/Medical Examiner	1 X Burial 2 Cremation 3 DR 1 Donation 5 Other (Specify) 21. Signature of Edneral Service License shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Gree Cuy cations that caused the death	Do not en	2. Name at leeg1 Decreption Box ter the mo	e and 160 de of dyin	ss of Facility d Helfer Greens g, such as cardi	nbein F sboro, ac or respirato	unera Maryl Dry arrest,	al Home P Land 216	Approximate Interval Between Onset and Death
9 9 9	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3[□Ectopic □ Other (s					23d. Date of deli Month	Day Year
law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con Status post p	ntributing to death but not resu	Iting in the C	anderlying	A Da	en in Part I.	4	1 🗆 Yes		the cause of death?
ate h	Completed	, ,						1 🗆 Y		prior to death?	atopsy findings availacompletion of cause 2 No No
rnysician: this certific ral director.	o Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2 I	ER/Outpatie	nt 3□ □	OA Oth	26. Place of D er: 4 ☐ Nursing			6 □Other (Spec	city)
ding After fune	Certification: T	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 6 Could not be	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	of M	28c. Injur Wori 1 🗍		28d. Desc	ribe how in	jury occurred	ural Route Number,
To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my known)			ne, date and pla	City o	r Town, Sta	ate)	
To the Hospitel within 24 hours a To the Funeral I completely filled	Medical		ner: On the basis of examinat and manner stated.		rvestigatio		pinion, death oc		ime, date a		to the cause(s)
To To		Christian & De	moenmo	W.H		214	664		M=	wich 09	3 200
Sta	ate rar	30. Name and address of person who co	mpleted cause of death (Item MD POB #6 82. Registrar's Signal	70 D	ENT	ON	MDa	162	9		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Cert	ificate of	Death		Reg. No.200	4 13014				
	Physician	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath	3. Time of Death				
	/Medical	NORMAN HENRY					March	15 2004					
	Examiner	4a Fecility Name (If not institution, give street a Talbot Hospice Ho				4b. City, Town, or Lo Easton		,					
_				at friedbyland	If Under 1 Year				11bot				
	Funeral Director	5. Social Security Number 6. Sex 13-22-7281 HDM 2	7. Age (In yrs. la	0, 0, 0, 0, 0, 0	Months Days	Hours Min.	8. Date of Birt (Month, Day Feb. 6	y. Year) , 1927 N	Birthplace (State or Foreign Country) laryland				
	b & and	10a. State 10b. County		Town or Loca					10d. Inside City Limits				
	Se-fehr offfied	MD Carolin	е			ralsburg			1 ☐ Yes 2 🖾 No				
	1 23 or 2	10e. Street and Number 2922 Mowbray Cree				1632		10g. Citizen of Wha United	States				
020	ed within 72 hours after deeth with the Meryland yglene. We than "natural", or items 23e or 28e-f ehow it, the Medical Examinar must be notified at Completed by Funeral Director	1 Never Married 2 X Married 1 K	s Decedent Ever in U,S ned Forces?] Yes 2 ☑ No 'es, Give ar or Dates:		as Decedent of I	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ocify Yes or No- Rican, etc.)	14. Race - Black, V Specify:	American Indian, White, etc. White				
5-0	72 h	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Deceder (Give kii	nt's Usual Occup nd of work done	pation during most of workind)	ng	16b. Kind of Busin	ess/Industry				
121	tel Hygiene. d other than event, the Me	Elementary/Secondary (0-12) Co	llege (1-4or 5+)			d) perator		Sand 8	Gravel				
D	= 1 = 2	17. Father's Neme (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Surname)					
lan		Clarence Johnson				Kate H	enry						
, Maryland 21215-0020	treum	19a. Informant's Name/Relationship <i>(Type, Pri</i> Valeria Henry/ Sp	•			and Number or Rura y Creek							
Baitimore,	Peges 1 en nent of Heeli nt: if Item 2: iry or other	20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	Liferan Charles COI		tory or other pla	metery 3	Date / 20 / 04	20c. Location - Cit Easto	y or Town, State				
alti	- ingrant.	21. Signature of Funeral Service Licensee	-	ess of Facility Fra									
m	e de	Moloal		h Main S	t.Fede	eralsbur	g, MD 21632						
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. se on each line.	Do not enter	the mode of dyi	ng, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between Onset and Death				
)	Physician / Medical	Immediate Cause (Final											
	Examiner	disease or condition resulting in death) a.		- 348ers									
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90,	oe axe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c							1				
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6	Signature of the state of the s	TU Yes 20 NO	1 Inpatient 2 LE	R/Outpatient 28b. Time of	3LI DOA			ence 6 MOther (Specify) HOSPICE NOUSE				
5	ding in After fune	1 Statural 5 Pending 2 Accident investigation	(Month, Dey Year)	Injury	28c. Inju Wo M 1	rk? Yes 2⊡No		ow injury occurred	VWJ-SE				
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	Hoapi 24 hour Funer stely fill	(Check only 2 Medical Examiner: Or	To the best of my knowl the basis of examination manner stated.										
	within 2 To the comple	29b. Signature and title of certifier	11	40	29c. Licens		1	29d. Date signed (A	fonth, Day, Year)				
		1 Defultale	deta "	S)	D36	0644		3/17/04					
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		31. Date filed (Month, Day, Year)	32. Registrer's Signatu		Dover	W AVE	EASTO	MM CM	21601				
	State Registrar	MAD 1 vy 2004	10 1	26									
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State of Maryland / Department of Health and Mental Hygiene 200413015 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DWARD 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) Itimore THE JOHN
5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Oct. 17, Birthplace (State or Foreign
Country) **Funeral** Days Hours 1**X** M 2 □ F 577-56-5315 60 1943 Wash, D.C. Oct. Director Usuat Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic avent, the Moulcel Exercities must be rectified at once. or 28a-f ahow 1 Yes 2 No D. C. Washington, D.C. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20001 62 Seaton Place, NW. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Back Hoe Operator District Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver T. Hill Corine Watts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 62 Seaton Place, NW. Washington, DC. Regina Edith Robinson/Spouse 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery | April 6,2004 Brentwood, MD. 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final 4 months **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner Physician: The law requires that the death certificate be executed use as the burial-tranresulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month 4☐ Pregnant at time of death signed by the a be detached f o 9 Unknown 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 PNo 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 : autopsy performed? 2 D No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Umpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manney of Death 28b. Time of Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 29c. License number march 31, 2004 2E5-000 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe ST Matthew Koenis Johns Hopkins Hopital Baltinore MD 21287 31. Date filed (Month, Day, Year) State APR 0 2 2004 Registrar

		1 - For State Registrar	State of M	larylar		artmen rtificat					Reg. No. 2	2004	13016
Physic /Med		Decedent's Name (First, Middle, La Virgie	Lee				kins		М	Date of De Month arch	29, Day 20		3. Time of Death 2:05 P M
Exami	ner	4a. Facility Name (If not institution, give LaPlata Center Ge	nesis ELd	ercar			Plata				Cha	nty of Death	
Funeral Director		5. Social Security Number 213–38–3533 Usual Residence of Decedent	5ex /.A 1□M 2∏XF	ge (in yrs. 81	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min Octob	Date of Bir (Month, Da er 3,	1922	9. Birthi Coul Mary	place (State or Foreign of try) Pland
e-f show	ctor	10a. State 10b. County Maryland Charles			ty, Town or Lo	cation							10d. Inside City Limits 12 Yes 2 No
th with the 23a or 28 181 be no	Funeral Director	10e. Street and Number 3515 Metro Gun E	lace			10f. Zip					10g. Citizen o	of What Cou	ntry?
1215-0036 within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-f show the Madical Examinar must be notitled at	Š	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? N o	1	Was Deced If Yes, spec 1 Yes		spanic Orig n, Mexican Specify:	gin? (Specify , Puerto Ric	/ Yes or No an, etc.)	i	Race - Ameri Black, White, cify: Bla	etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28e-f show eny injury or other traumatic event, the Maritral Examinar must be notified at once.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		5+)	(Give	DO NOT us	rk done d	lurina most	t of working		16b. Kind of	Business/Instic	dustry
yland Z ould be filed Mental Hyg wrked other netic event, I	To Be C	17. Father's Name (First, Middle, Last Benjamin	Makle					Marga	aret			akle	Hawkins
altimore, Maryland mit. Pages 1 and 2 should be file partment of Health and Mental Hy portant: If tiem 27 is marked oth y injury or other traumatic event		19a. Informant's Name/Relationship (Mary Booth/ Step 20a. Method of Disposition	Daughter			Pop]	ar H	ill F		dorf,	er, City or Tov Marylai 20c. Locatio	nd 206	01
Baltimo permit. Page: Department of Important: If i eny injury or		\$\frac{1}{2}\text{Burial} 2 \text{ Cremation} 3 \text{ Cremation} \ 4 \text{ Donation} 5 Other (Special Policy Control	fy)	9	Peters	Cath	Ch	1			Waldor	f,Mary	rland
death certificate be executed the attending physician and properties of for use as the burial-transit		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a c. Due to (or a	s a consec	uence of):	atic	0	are	iner	na	of c	olon.	Onset and Death
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ecords, P.O law requires that the as been signed by th	by	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying c	ause give	n in Part I.			obacco use co Yes 2 □ No		he cause of death?
I Reco	Completed											b. Were auto prior to co death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
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Division tall or Attending is after death. al Director: After ed in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not to the determined determined	28e. Place of Ir	njury - At h etc. <i>(Speci</i> i			-		-	Location (City or To		mber or Rura	al Route Number,
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MP 10	ate	30. Name and address of person who NIR MIN CADEV 31. Date filed (Month, Day, Year) APR 0 2			m 23a) (Type, 332S) ature	Print)	o W	X 5 41	1N650	N R	LDAP. (WALE	20602
Regis	trar	APR 0 2	ZUU4	Mess	J.	GOOG	1						

			1 - For State Registrar AMEND ITEM	State of Maryland #26 PER PHY G					giene Reg. No	2001	. 1301	-
			Decedent's Name (First, Middle, Last					2. Date of De. Month	ath Da	v Year	3. Time of Death	
	Physicia		Clyde Ambrose	Jones				April 3	3, 2	004	6:30 A M	
)	/Medic Examin		4e. Fecility Name (If not institution, give			4b. City, Town	or Location of Dea			. County of Deeth	1	
			13 Greystone Circ	le		Waldorf			Ch	arles		_
	Funeral		Social Security Number 6. Se	the one		If Under 1 Year Months Day			th y, Year	9. Birth	place (State or Foreign untry)	
	Director		218-03-5839	87	Yrs.			Feb. 3,	191	17 Penns	sylvania	_
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits	
	lanyli	5	Marvland Charles	Ma I	dorf						1 ☐ Yes 2 / ☐ No	
	the h	Directo	Maryland Charles 10e. Street and Number	Wal	uori	10f. Zip Code)		10g. Ci	itizen of What Cor	untry?	-
	with with	ā		1.		00000			Uni	ted Stat	00	
	ns 23	Funeral	13 Greystone Circ	Was Decedent Ever in U.:	S. 13.	20602 Was Decedent o	f Hispanic Origin?	(Specify Yes or No		14. Race - Amer	ncan Indian,	_
0	riter	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 MYes 2 □ No 194 If Yes, Give	4-		uban, Mexican, Pue	erto Rican, etc.)		Black, White	etc.	
3	al', o	by	3 X Widowed 4 ☐ Divorced	Year or Dates: 194	5	1⊡Yes 2∭XN	o Specify:			Specify: Wh	ite	
, C	d within 72 hours after death with the Marylan jene. r then "natural", or items 23a or 28e-1 ehow the Marical Examination interioritied at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occ	ne during most of w	vorking	16b. F	(ind of Business/I	ndustry	
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<u>n</u>	be filed tta! Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)				11			п эшпате)		
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Maryland 21215-0036	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (7								ip code)	
e,	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Sheila Crossley 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Waldorf,		ocation - City or	Town, Stete	-
و	Pages nent of I ant; If it		1 ☐ Burial 2 X Cremation 3 ☐	Removal from State		matory or other p	F	05 0004				•
Baltimore,	permit. Pag Department Importent; I any injury o		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen,			ematory 2. Name and Add		05-2004	wai	dorf, Ma	ryland	_
Ba	permit. Pages Department of Importent; If I any injury or one		Tack H. Wil	101240	Hι	ıntt Fun	eral Home	9	-			
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		İ	shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	Pin	Colom	1 (0				Interval Between Onset and Death	
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Ö	after after Dire	Certification:	4 Homicide	building, etc. (Specify	v)			City or To	wn, Stat	re)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is			ysicien: To the best of my kno								_
	n 24 l n 24 l ne Fu	Medical	(Check only 2 Medicel Exam	niner: On the basis of examina and manner stated.	tion and/or ir	ivestigation, in m	y opinion, death oc	ccurred at the time,	date ar	no place, and due	to the cause(s)	
	To the To the Comp	ž	29b. Signature and title of Certifier	MD		29c. Lice	ense number	60	29d. D	ate signed (Month	n, Day, Year)	
)			Mance	IND		D	007/11)		115104		
			30. Name and address of person who	completed cause of death (Item	23a) (Type	Print) Per	Shak S	ig, wa	ldi	J. MD	20603	
1	18 134 IVI	1	7 1 3 1	interen, MI) 1136	77 16.00	-V, V	1 1		Λ,		_
	Sta		31. Date filed (Month, Day, Year) APR 0 6	32. Regentar's Signa	ture	Somet s						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Harding Jameson 10 2004 April Dorothy 8:40 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LaPlata

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)

Dec. 19, 19 Charles Civista Medical Center 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2□F Months 578-14-7759 87 1916 Ft. Monroe, VA Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any hjury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 Yes 2X No Funeral Director Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20602 3394 Old Washington Rd 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 💢 No Specity: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Charles County Coltege (1-4or 5+) 5+ Elementary/Secondary (0-12) Librarian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (ပ Ray Harding Mabel Briggs 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3394 Old Washington, Rd., Waldorf, MD Jerone V. Jameson - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 04/18/2004 Waldorf, MD 22. Name and Address of Facility
Huntt Funeral Home
P.O. Box 156, Waldorf, MD 21. Signature of Moneral Service Licensee M01391 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6 Physician T disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown been signed by should be detac Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was en autopsy performed? 1□ Yes 2 100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 3□ DOA Certification: To 2 ER/Outpatient 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t s after dea. Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CI D-28352 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan M Mathur, MD 3500 Old Washington Rd Suite 102 Waldorf MD 20602 31. Date filed (Month, Day, gistrar's Signatur 32. F State Registrar

		1	For State Registrar	State of Ma	ırylan			t of He		Menta		ene . No. 200	4 13019
	sicia edica	n 1	1. Decedent's Name (First, Middle, La Harry			Jone				Apr			
	mine		ta. Facility Name (If not institution, given Calvert Memor 5. Social Security Number 6. S	ial Hosp		- last birthday)	Prin	ice I	ocation of Dea reder	ick	e of Birth	4c. County of Dea	vert
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DESILLINOTE, INIGITY ISING 2 L 2 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23e or 28e-f show minimity of the control of th		rai Director	10e. Street and Number 55 Kyler Ro	vert ad 12. Was Decedent E Ammed Forces?			lunti 10f. Zip 2	0639		Specify Yes		. Citizen of What C USA 14. Race - Am Black, Wh	erican Indian,
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To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funderel Director: After this certificate has in completely filled in but he timesel director goes 9.		2	examiner? 1		,	ER/Outpatien 28b. Time of Injury		A Other: 3c. Injury a Work?	26. Place of De 4 Nursing t s 2 No	Home 5	Residenc	e 6 ⊡Other (<i>Spe</i> injury occurred	ocify)
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To the Ho within 24 f			(Check only one) 2 Medical Exer	niner: On the basis of and manner stat	examinat ed.	ion and/or inv	estigation,	License n	ion, death occ	urred at the	time, date	and place, and due Date signed (Mont	th, Day, Year)
2			30. Name and address of person who Dhiren Shal 31. Date filed (Month, Day, Year) APR 0	completed cause of de	ath (Item	23a) (Type, I	Print)	Prin	4 1	يه و ع ما	di	MD	20678
Reg	State Jistra	e	31. Date filed (Month, Day, Year) APR 0	6 2004 A	s Signa	ture &	for	the same					

State of Maryland / Department of Health and Mental Hygiene 2004 13020 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Jones Joseph Lee 1, 2004 Apri1 6:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 184 Sansbury Road Anne Arundel Friendship | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | O C t . 16 , 1951 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □ F 217-58-1700 52 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Examiner trust be notified at Maryland
10e. Street and Nu
184 1 Tyes 2 No Friendship Anne Arundel the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20758 USA 184 Sansbury Road or Items 23a Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Masonry Bricklayer 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jones Rebecca Coates Ernest 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Jones/mother P.O. Box 118 Friendship, MD 20758 other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Carter's UMC Cem. 4/6/2004 5 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Friendship, MD * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD2067 Glocky 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hepato cellular /Medical Due to (or as a consequence of): Examiner chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician by Physician/Medical as the IF FEMALE esn esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be a 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 25 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D40210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA Owens ville Rd, West River, MD 20778 eslie F. Brooks MD 32. Registras Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

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₹.	Funeral		5. Social Security Number 6. Se	X 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (Stete or Foreign
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Σ	l or Attsno after death Director:	it.	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	eet, ractory, onice	-	City or Town,	State)	II noute Number,
	pitel ours a eral filled		29a. Certifier 1 Certifying Ph	vsician: To the best of m	v knowledge, deat	n occurred at the tir	me date and place a	nd due to the cau	se/s) and manner as s	tated
	To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicampletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Exam	iner: On the basis of exa	mination and/or in	vestigation, in my	opinion, death occurre	d at the time, date	and place, and due to	the cause(s)
_	othe ithin o the omple	Me	29b. Signature and title of certifier	^		29c. Licens	se number	29d	I. Date signed (Month,	Dey, Year)
	- > - 0		DI/Anni	4/200/10	AA M	0	75/639		4-7-1	4
			30. Name and address of person who	ompleted cause of death	(Item 23a) (Type.					<i>[</i>
			Dr. Karen Moffett	, 609 Daffin	n Lane, I	enton, M	D 21629			
	Sta	ite	31. Date filed (Month, DayA) OR 0	8 2004 Registra's	Signature	had.				
	Dogist		#31_31 U	- LUVII JEF	TARRES OF THE					

			1 - For State Registra AMEND ITEM #26	State of Ma	•	•			nd Mental		00	04	13024
é			Decedent's Name (First, Middle, Last)						2. Date of	of Death	Day		3. Time of Death
	Physici. Medio/		Anna Marie Jenkin	S					Marc			99ar 004	9:20PM
A.	Examir		4a. Facility Name (If not institution, give s					Location of	Death		4c. County of		
			13807 Longridge R		4			town	L Hen La D		Washin		County
47	Funeral Director		218-24-9453	M 2 🔀 F	(In yrs. last birth 75 Yr	Months	Days	If Under 24 Hours		i, Day, Ye	1928		place (State or Foreign htry) yland
	fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			<u> </u>			1	0d. Inside City Limits
	Mary F-f sh	to	Maryland Washingt	on	Hage	rstown							Yes 2 No
	th the	lrec	10e. Street and Number			10f. Zip	Code			10g.	Citizen of W	hat Cour	ıtry?
	23a	ral	109 Devonshire Ro	ad			2174				U.S.	Α.	
21215-0036	filed within 72 hours after death with the Maryland Hygiene wher than "natural", or Items 23a or 28s-f show with the Medical Executive Controllies and	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Every Armed Forces? 1 ☐ Yes 2		13. Was Deced If Yes, spec		spanic Origii n, Mexican, I Specify:	n? (Specify Yes o Puerto Rican, etc	r No- .)	Black	- Americ k, White, Whi	
Ö	72 hou	Completed	15. Decedent's Educ (Specify only highest grade		16a. D	ecedent's Usua Give kind of wor	al Occupa	ation	of working	166	o. Kind of Bus	siness/Ind	dustry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+	/	fe. DO NOT us	e retired)	ii working				
	led w lygien her th	Cor	8		H	omemake	er	40.14-11-1					sidence
and	ntai H od ott	Be	17. Father's Name (First, Middle, Last)						s Name <i>(First, Mi</i> Vanni G			9)	
Ē	should ad Me mark matic	2	Antonio Pennesi 19a. Informant's Name/Relationship (Type	oe. Print)	19b. A	failing Address	(Street a		or Rural Route N	rasso		State Zin	Code
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items any injury or other traumatic event, Ite Marical Exc.		Charlene Cearhart 20a. Method of Disposition 1XX Burial 2 Cremation 3 Rev. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	A	Rest Ha	isposition (Nan crematory or o	ne of ther place reter	e) Cy Ma	Date ar. 31,0	4 Ha	agerst	OWN,	Maryland
B	Ded Imi		23a. Part1 Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	cations that caused the cause on and line								Mary	ral Home land 21742 Approximate Interval Between
8760,	The law requires that the death certificate be executed as the has been signed by the attending physicien and bagge 2 should be detached for use as the burial-transit as	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of) consequence of)								
O. Box 6	that the death certifice led by the attending ph detached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐Ectopic pro					23d. Date Mont		ory Day Year
٥.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but	not resulting in the	ne underlying ca	DV2	en in Part I.	ρ	Oid tobacc			e cause of death?
al Records,	: The law requ cate has been page 2 shoul	Completed				_()			a	Mas an autopsy performed as 2 2	pr de	ior to con eath?	osy findings available npletion of cause of
Vital	stcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe	er.	Death (Check of	_			DAUCHIER's
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation; To	1 Yes 2 No 27. Manny Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b. Tim		8c. Injury Work	4 U Nursi			njury occurre		residence
Divis	al or Attendes safter death al Director: ad in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, farm (Specify)	, street, factory	, office		28f. Location City on	on (Street Town, St	t and Number tate)	r or Rurai	l Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	xamination and/o	leath occurred a or investigation,	at the tim in my op	e, date and p sinion, death	place, and due to occurred at the ti	the cause ne, date	e(s) and man and place, ar	ner as stand due to	ated. the cause(s)
,	To the within To the comp	Me	29b. Signature and title of certifier	ng_1	MI)	290	License	Turber	86	29d:	Date signed	(Nionin, E	Day, Year)
	2H-7		30 Name and address of person who con	mpleted cause of dea	th (Nem 23a) (T)	pe Print	2/	Onle	2 hill	ave,	Ha	ger	stewy !
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 2	72. Registrar	s Signature	Specie	/				MID	11.	192

		For State Registrar	State of Maryland / D	epartment of Health and Certificate of Death	Mental Hygi	
Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last, Mond Last, Sa. 4a. Facility Name (If not institution, give	laction	4b. City, Town, or Location of Dea	2. Date of Death Month	
Funeral Director		869 N. Ohio Stree 5. Social Security Number 445-56-7991	7. Age (In yrs. last bint	Havre de Grac	e 8. Date of Birth	Harford
he Maryland 8a-f show	Director		10c. City, Town	Havre de Gr	ace	10d. Inside City Limits 1 ☐ Yes 2 🛣No
th with t	al Dir	10e. Street and Number 869 N. Ohio Str	eet	10f. Zip Code 21078	100	g. Citizen of What Country? USA
72 hours after death with the Maryland natural, or Items 23a or 28a-1 show dical Examiner ment be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue) 1 ☐ Yes 2 ☒No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
filed within 72 ho Hygiene. Ither than "natur inf, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) (College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of wo life. DO NOT use retired) eqistered Nurse	rking	Bb. Kind of Business/Industry Hospital
d 2 should be filed within 72 hours aft it and Mental Hygiens 18 is marked other than "natural", or traumatic event, the Medical Example	To Be C	17. Father's Name (First, Middle, Last) Moses Lurks	•	18. Mother's Na Lucille	me (First, Middle, Me Williams	oiden Sumame)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mandal Hygiens. Important: If item 23a or 28a-1 show may injury or other traumatic event, the Macing Examination than the notified at DRS.		19a. Informant's Name/Relationship (Ty George A. Jackson 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☑ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State State Evergr	Mailing Address (Street and Number or R 59 N. Ohio Street, 1 Disposition (Name of crematory or other place) Teen Cemetery 4/ 22. Name and Address of Facility	Havre de G	
Physician /Medical Examiner By a the private ransit as the private range ransit as the private range ransit as the private range range range range range ransit as the private range	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Do not be cause on each line. It is not to (or as a consequence of the conse		c or respiratory arrest	de Grace, MD 21078 Approximate Interval Between Onsel and Deall
The law requires that the death certificat tte has been signed by the attending phy bage 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed b should be deta	by	Part II. Dther significant conditions con	tributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 TNo 3 Probably 4 Unknown
	e Completed	25. Was case referred to medical		26 Place of Dec	24a. Was an autopsy performed 1 Yes 2 3ath (Check only one)	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ng Phys Iter this neral dir	ation; To B	27. Manne Death 1 Autural 5 Pending 2 Accident investigation	ospital: 1 □ Inpatient 2 □ ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tin Inju	nation 3 DOA Other: 4 Nursing F		e 6 ⊡Other (Specify) injury occurred
ne Hospital or Attending n 24 hours after death. ne Funeral Director: Afte eletely filled in by the fune	I Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, S	
To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	29b. Signature and title of certifier	Por: On the basis of examination and/of and manner stated. Tacklison, M. L.	death occurred at the time, date and place or investigation, in my opinion, death occurred. 29c. License number	rred at the time, date	e(s) and manner as stated, and place, and due to the cause(s) Date signed (Month, Day, Year) 4, 2, 4
Sta Registr		30. Name and address of person why co HOWLEST Jack 31. Date filed (Month, Day, Year) APR 0 6 2004	32. Registrar's Signature	ppe, Print) 611 5. UNION	he Ha	vve DeGrace MD210.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3rd 3:10AM April HAN CHANG KING /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC 4 1923 Birthplace (State or Foreign Country)
 China 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 ☐ F Months Director 095-52-6820 80 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28e-f show 1 XYes 2 No Maryland Charles Waldorf Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code China 20601 4460 Jorden Lane or Items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2☐XNo 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: intal Hygiene. ed other than "nature event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laundry/Cleaning Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fit and Mental F Unknown Unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 Aimei K. Hsieh (Daughter) 4460 Jorden Lane Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Importent: If it any injury or o 1 □ Buria 2 □ Cremation 3 □ Removal from State 4 □ Donytion 5 □ Other (Specify) Trinity Memorial Gardens 4-10-04 Waldorf, MD 22. Name and Address of Facility Eberwein Funeral Services M00173 4433 White Pls. La. White Pls., MD 20695 Vascular disease distal aortic Occlus Approximate Interval Between Onset and Death Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. diate Cause (Final Impediate Cause (Fi disease or condition resulting in death) Derphoval Physician /Medical Examiner ound Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Chemic use as the burial-transit The law requires that the death certiticate be executed Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Box 68760,

land

within 24 hours after To the Funeral Direc

State Registrar

completely

Medical

29a. Certifier

(Check only one)

29b. Sig ature a

750

Surralls

29c. License number

29d. Date signed (Month, Day, Year)

Road, Suite 303, Clinton, mD 20735

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day **Physician** Month Bernard William Kernan March 18, 2004 7:30 AM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Frederick Kline Hospice House Mt. Airy If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**☆**M 2□ F Months Days Hours 137-28-4121 Director 69 New Jersey 20, 1935 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shor the Medical Examinar must be notified at Maryland 1 ☐ Yes 2 🖾 No Directo Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14336 Shirley Bohn Road 21771 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decadent Ever in U,S. Armed Forces? 11. Marital Status 14. Raca - American Indian. Black, White, etc. 152Yes 2 No If Yes, Give 1959 Year or Dates 1959 6 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ۾ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Dog Show Photographer pemit. Pages 1 and 2 should be filed.
Department of Health and Mantal Hygic important: If Item 27 Is marked other? any injury or other traumatic event, # Photography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Kernan Rose Margaret Brett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Kernan / Wife 14336 Shirley Bohn Rd., Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 19 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Frederick, Maryland Resthaven Crematory 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Furral Service Licensee 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Ent. if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner sician and buriel-transit To the Nospital or Attending Physician: The law requiras that the death certificate be associated within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the ettending physician and complataly illiad in by the funeral director, page 2 should be deteched for use as the buriet-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 1€ No 3 Probably 4 Unknown Ś Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 - 100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 45 PICE Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of contified 29c. License number 29d. Date signed (Month, Day, Year) MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Ronald EMi

DHMH 16 Rev 6/95

Registrar

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32. Registrar's Signature

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2004

31. Date filed (Month, Day, Year)

event, the Medical Examination confidence and a second confidence and a second confidence and co	4a. Facility Name (If no Homewood 5. Social Security Num 212-38-91 Usual Residence of De 10a. State 10b. Street and Number 7407 Willo 11. Marital Status 1 Never Marned 3 Widowed 4 1	at Crumla at Crumla at Crumla aber 6. Sex 92 1 ecedent 10b. County Frederick eer DW Road	and Farms	e (In yrs. Id	4t Fast birthday) If		ar If Under 2	Ma f Death		y Year	3. Time of Deal 12:45 A
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"natural", or Items 23e o edical Examinational by	3 Widowed 4	w Road			rederick	C 10f. Zip Cod	le		10g. Cit	tizen of What Co	untry?
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letec	14	Divorced	If Yes, Give Year or Dates:			Yes 2☐X	No Specify:			Specify: W	hite
	(Specify	5. Decedent's Educ	ation completed)		16a. Decedent	s Usual Oc	cupation one during most	of working	18b. K	(ind of Business/	Industry
3 0	Elementary/Second		College (1-4or 5	5+)	life. DO	NOT use re	ne during most tired)				
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ouce	21. Signature of Fune 23a. Part Enter the shock, or heart f	UE-1	I su	the death	120	1 NOR	TH MARK	ET_ST.	N FUNERA FREDER		21701
ician dical niner	shock, or heart f Immediate Cause (Fir disease or condition resulting in death)		Durit (or as	iten	sine		ioVno			ine	Interval Between Onset and Death
je	Sequentially list condi- if any, leading to immi- cause. Enter Underly	litions, b. dediate ring	Due to (or as	a consequ	uence of):						******
burial-transit	5	C.	Due to (or as	a consequ	uence of):						
s the											
igned by the attending prysty be detached for use as the top to the VP Physician/Medica	IF FEMALE: 23b. Was decedent pi in the past 12 pm 1 Yes 2 N 9 Unknown	regnant	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant ai 9 ☐ Unknown	2 Fetal	death 3 Ec	topic pregna ther (specify				23d. Date of deli Month	very Day Year
d be detact	Part II. Other significa	ant conditions cont	tributing to death b	ut not resu	ulting in the unde	rlying cause	given in Part I.	2		V _	the cause of death
								-		X ONO 3□Pro	
is certificate has been s director, page 2 should To Be Completed									4a. Was an autopsy performed?	prior to death?	topsy findings avail completion of cause 21 No
sertifi ector Be		H	ospital:					of Death (Che			
After this o funeral dire		0	1 ☐ Inpatie		ER/Outpatient 28b. Time of	3 DOA	4 X NUI		5 Residence Describe how inju		cify)
ion	Natural	5 Pending	(Month, Da	y Year)	Injury		njury at Work? 1 □ Yes 2 □ N		rescribe now inju	ry occurred	
completely filled in by the funeral Medical Certification: 1	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Place of Ini building, et	ury - At ho c. (Specify	ome, farm, street,			28f. L	ocation (Street ar lity or Town, State		ral Route Number,
pletely filled	29a. Certifier 1, (Check only 2, one)	Certifying Phys		f examinat							
To the Funeral Director: A completely filled in by the fi	29b. Signature and titl	tle of certifier	20/1		-	29c. Lic	ense number		29d. Da	ite signed (Month	n, Day, Year)
• 0	1 XJ	forta.	Karfin	n		D-	13971	1	31	15/04	
2.	30. Name and addres	s of person who cor	mpleted gause of o	leath (Item	1 23a) (Type, Prir	nt)			-		
	Robert L.	Kaufmann	1, MD 30	0 Wes	st 9th S	treet	, Frede	rick, N	D 21701		
State	24 2 4 64 4 64 44		32. Registr								

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			1 _ For State	State of Mar			it of Health e of Deat			eg. No. 2001	. 12020
			Registrar		Cel	uncai	e oi Deali		2. Date of Deat		3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Las	*					Month	Day Year	
	/Medic	al	4a. Fecility Name (If not institution, give			Ab Ciby	Town, or Location	o of Death	4	4c. County of De	1/0/
	Examin	er				40. Ony,					
	Funeral		Carroll Hospital 5. Social Security Number 6. Secu		In yrs. last birthday)			er 24 Hrs.	8. Date of Birth	Carro]	rthplece (Stete or Foreign
	Funeral Director			@M 2□F	81 Yrs.	Months	Days Hours	Min.	(Month, Dey,	Yeer) (MD
	D	Ì	Usuel Residence of Decedent						1101		
	irylan show		10a. State 10b. County	1	Oc. City, Town or Lo	cation					10d. Inside City Limits
	Ba-f	cto	MD Carro)11	West	tmins					
	or 2	Dire	10e. Street and Number	. D 3		10f. Zip	Code		1	0g. Citizen of What 0	Country?
	72 hours after death with the Maryland naturel', or Items 23e or 28e-t show Jical Examiner must be notified at	Funeral Director	809 Stone Chapel			W D	21157	Daining (Con-	-if. Van as Na	USA	no dean Indian
	er de Item	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Eve Armed Forces? 1 XYes 2 No	er in U.S. 13.	was Dece If Yes, spe	dent of Hispanic (cify Cuban, Mexic	an, Puerto F	Rican, etc.)	Black, Wh	
36	l', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2⊠No Specif	fy:		Specify: V	hite
215-0036	2 hou	ed	15. Decedent's Ed	lucation	16a. Dece	dent's Ųsu	al Occupation			18b. Kind of Busines	s/Industry
215	within 72 lene. then "nu	pie	(Specify only highest gra	de completed) Coflege (1-4or 5+)	(Give	kind of wo DO NOT u	ork done during mi ise retired)	ost of workin	19		
21	d with	Completed	12]]	Posta	1 Carrie	r		Postal Se	rvice
PL	al Hy	Be (17. Father's Name (First, Middle, Last)				18. Mot	ther's Name	(First, Middle, I	Maiden Surname)	
<u>/la</u> i	should be filed with nd Mental Hygiene, marked other the	To	John E. Long, Si	2			Ca	roline	E. Sny	yder	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene it the T 1s marked other transmission of Examiner name be notified at other traumatic event, the Modical Examiner name be notified at		19a. Informant's Name/Relationship (•				, City or Town, State,	
2	and lealth m 27 her tu		Dorothy Long/wife	<u> </u>	20b. Place of Dispo					inster, MI 20c. Location - City of	
Ore	ges 1 t of F if ite or of		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemetery, crer	matory or	other place)				
tim	t. Pa rtmen rtant:		`4 □Donation 5 □Other (Specify		Leisters			4/10,	/2004	Westminst	er, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other		21. Signature of Funeral Service Licen	2	Pa	ritts	nd Address of Fac Funeral	. Home	and Cha	apel, P.A.	
			23a. Part1. Enter the disease, or com	plications that caused th						inster, M	21157 Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Ccror		A.	Disens	~			75
	Examiner			Due to (or as a c	consequence on.						
	- · · · · · · ·	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):						
	e be executed sician and e burial-transit	Examiner	that initiated events	C							
,09	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as a c	consequence of);						
	ate be hysici	licai		d							
, e	certificate Iding physise as the	Mec	IF FEMALE:								1
Вох	death co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetel death 3	Ectopic p				23d. Date of d Month	elivery Day Year
	w requires that the death certificate been signed by the attending phy: should be detached for use as the	Completed by Physician/Medic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□ Unknown	ne or death 5 L	Other (s	ресіту)				
P.0	law requires that the as been signed by th 2 should be detache	Ph.	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying	cause given in Par	rt I.	23e. Did tol	pacco use contribute	to the cause of death?
Records,	uires sign id be	d b	1dyne	ndenson					1 🗆 Ye	s 2 No 3 1	Probably 4 Unknown
202	A req	iete							24a. Was a	n 24b. Were a	autopsy findings available
Re	sicien: The law s certificate has b irector, page 2 s	щ							autops	ned? prior to death?	completion of cause of
	ificate or, pa		25. Was case referred to medical				ae Dia	co of Doath	(Check only on	-	s 2 No
of Vital	Physicien: r this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 DER/Outpatier	nt 3 D	Other			ence 6 Other (Sp	ecify)
0	ding Physicien: The th. After this certificate ha funeral director, page		27. Manner of Death	28a, Date of Injury	28b. Time o		28c. Injury at Work?			ow injury occurred	
ion	Attending r death. actor: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	(eer) Injury	М	1 Yes 2	□No			
Division	ar der	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pface of Injury building, etc.	- At home, farm, str	reet, factor	y, office	2	8f. Location (St City or Town	reet and Number or F	Rural Route Number.
Ö	rs afte al Dir	Cer		, and a second							
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	icai	(Check only 2 Medical Exam	ysician: To the best of a	xamination and/or in						
	within 24	Medical	one)	and manner state			c. License numbe			9d. Date signed (Mor	
	\$ \$ \$ \$ \$		29b. Signature and title of certifier	1 MOS	0.17 14	41 1	D 0 0 4-1	~		Woloy	507, 1001/
1	1 Vense		Joseph Joseph	J.	DI Kerski	MU Brist	U935	14		401111	
	75 %		30. Name and address of person who		etrunder	Print) 5	n 2/11.4	57			
	Sta	te	31. Date filed (Month, Day, Year)	32. Regigifar's		100	J 2 1. C				
- ile	Regist		APP n o		m. K	Man	1. 1				

			1 - For State Registrar	tate of Maryland / Depart	artment of Health and rtificate of Death	Mental Hygie	ne 2004 130	30
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give stree	ence Lowr	14b. City, Town, or Location of De	2. Date of Death Month	Day Year 3. Time of Death	
MAN	Funeral Director	۲	Carroll Hospital 5. Social Security Number 6. Sex 1 1 1 M	7. Age (In yrs. last birthday)	Westminste If Under 1 Year If Under 24 H Months Days Hours M	rs. 8. Date of Birth	Carroll	reign
LOW	vith the Maryland or 28a-1 show	Director	Usual Residence of Decedent 10a. State 10b. County MD Carroll 10e. Street and Number	10c. City, Town or Lo Westmi	nster		10d. Inside City Li 1 ☐ Yes 2 f	
NCE	er death w Items 23a	by Funeral	4465 Chilcoat Dri 11. Marital Status 1 □ Never Married 2 ☑ Marned 3 □ Widowed 4 □ Divorced	Vas Decedent Ever in U.S. 13. \ Immed Forces? 21 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	10f. Zip Code 21158 Nas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Puri	(Specify Yes or No- erto Rican, etc.)	Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White	
JOHN LAWRENC Baltimore Maryland 21215-0036	should be filed within 72 had Mental Hygiene. marked other then "nati	e Completed	15. Decedent's Educatio (Specify only highest grade core Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		Jent's Usual Occupation kind of work done during most of w DO NOT use retired) eral Inspector 18. Mother's N		JS Customs	
/ /	d 2 should be th and Mental 7 Is marked o traumatic eve	To Be	John W. Lowman 19a. Informant's Name/Relationship (Type, F		Jea g Address (Street and Number or I	n Marshal Rural Route Number, Ci	1 ty or Town, State, Zip Code)	
OHN I	permit. Pages 1 and 2 Department of Health Important: If item 27 I eny injury or other tre onge.		Deloris Lowman-Wi 20a. Method of Disposition 1 Ø Burial 2 □ Cremation 3 □ Remo `4 □ Donation 5 □ Other (Specify)		Chilcoat Dr.	Westmins Adday Westmins	Ster, MD 21158 Location - City or Town, State Finksburg, MD	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death)	diale Li	or the mode of dying, such as cardi	aple Ave.	Littlestown, PA Approximate Interval Between Ons. 1 and Death	1
3760.	ite be executed ysician and he burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence of): Due to (or as a consequence of):			· · ·	
P.O. Box 68	death cert e attendin ed for use	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contribut	ing to death but not resulting in the un	derlying cause given in Part I.		o use contribute to the cause of death?	
tal Rec	hyaician: The law I nis certificate has b I director, page 2 st	Completed	25. Was case referred to medical	MINGIOMA		24a. Was an autopsy performed 1 Yes 2 15	24b. Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2 🗷 No	ıble of
Division of Vital Records.	Attending Phyaician: r death. sctor: After this certific by the funeral director.	ation: To Be	examiner? 1 Yes 2 No Hospit	al: 1 Inpatient 2 ER/Outpatient a. Date of Injury (Month, Day Year) al: 1 Inpatient 2 ER/Outpatient a. Date of Injury	Oth	Ath (Check only one) Home 5 Residence 28d. Describe how in		
Divis	To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	al Certification;	3 Suicide 4 Homicide 4 Homicide 4 Could not be determined 28. 29a. Certifier 1 Cortifying Physician	Place of Injury - At home, farm, stre- building, etc. (Specify) To the best of my knowledge, death	Occurred at the time, date and place	City or Town, Sta	Name and an arrangement of the state of the	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medical	(Chock Chi) 2 medical expininer.	on the basis of examination and/or invend manner stated.	29c. License number	urred at the time, date a	and manner as stated and place, and due to the cause(s) Date signed (Month, Day, Year)	
	5 5		10. Name and address of person who complete Philip J Ruzbo	usky mo 125	Airport Drive.	Ste 34 Westmi	04 105 12004 nster, MD 21157	
>	Sta Registra		31. Date filed (Month, Day, Year) APR 0.8.200	32. Registrar's Signature	Saul ;			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 14 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Dav Ruby Lee Lester April 12 /Medical 2004 1130 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1049 Golden West Way Lusby Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 6 | 911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
Texas **Funeral** 1 ☐ M 2 🖵 F 453 22 2341 Director Yrs Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28e-f show Examples roust by rotified at Maryland Calvert Lusby 1 Yes 2 No Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 1049 Golden West Way 20657 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by Specify: white 3 Widowed 4 Divorced "natural", the Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event, Item. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Lee Russell Ruby Rosalie Neely ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodrow Lester- husband 1049 Golden West Way Lusby, Maryland 20657 20b. Place of Disposition (Name of 20a. Method of Disposition Charles Memorial Gardens 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4405 Broomes Is. Rausch Funeral Home 20676 Rouns 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PREUMONIA disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): Examiner ONCESTIVE HEART CAILURE Sequentially list conditions, if any learning land cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner I or Attanding Phyalcian: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal deat
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Junknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? KENALFAILURE 2₽No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title o

31. Date filed (Month, Day, Year) 32. Registras Signature 2004

pleted cause of death (Item 23a) (Type, Print)

Prince Frederick

29d. Date signed (Month, Day, Year)

10

29c. License number

40037228 MO

			4 17.	artment of Health and Mental Hygie rtificate of Death	ene .no. 2004 3032
	Physic		1. Decedent's Name (First, Middle, Last) James C. Lanham, S	Sr. 2. Date of Death Month March	Day Year 29, 2004 5:30P M
	/Medi Examii		4e. Fecility Name (If not institution, give street and number) St. Mary's Nursing Center	4b. City, Town, or Location of Death Leonardtown	4c. County of Deeth St. Mary's
	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Yrs. Usuel Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. May 2.5 ,	eer) 9. Birthplace (Stete or Foreign Country) South Caroli
3altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23s or 28s-f show shy injury or other traumatic event, its Medical Examinat must be notified at ance.	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Low Maryland St. Mary's 10e. Street and Number 48375 Sea Side View Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mon ft Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Deceded (Give Internation Specify only highest grade completed) 16a. Deceded (Give Internation Specify Only highest grade completed) 16a. Deceded (Give Internation Specify Only highest grade completed) 16b. Deceded (Give Internation Specify Only highest grade completed) 16c. Deceded (Give Internation Specify Only highest grade completed) 16b. Deceded (Give Internation Specify Only highest grade completed) 16c. Deceded (Give Internation Specify Internation Specify Only highest grade completed) 16c. Deceded (Give Internation Specify Only highest grade completed) 16c. Deceded (Give Internation Specify Only highest grade completed) 16c. Deceded (Give Internation Specify Only highest grade completed) 16c. Deceded (Give Internation Specify Only highest grade completed) 16c. Decedent Specify Only highest grade completed (Give Internation Specify Only highest grade completed) 16c. Decedent Specify Only highest grade completed (Give Internation Specify Only highest grade completed) 16c. Decedent Specify Only highest grade completed (Give Internation Specify Only highest grade completed) 16c. Decedent Specify Only highest grade completed (Give Internation Specify Only highest grade completed) 16c. Decedent Specify Only highest grade completed (Give Internation Intern	Ridge 101. Zip Code 20680 Was Decedent of Hispanic Origin? (Specify Yes or No- 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Sent's Usual Occupation kind of work done during most of working Ctronic Technician 18. Mother's Name (First, Middle, Mail Mae Belle 19. Address (Street and Number or Rural Route Number, C Box 333 Ridge, M Sition (Name of natory or other place) en Mem. Park 4/3/2004 G	Ryan ity or Town, State, Zip Code) D 20680 c. Location - City or Town, State reat Mills, MD
8760, Ba	Physician /Medical Examiner	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Name and Address of Facility Sewell Fun 451 Dares Beach Rd. Pri er the mode of dying, such as cardiac or respiratory arrest, and Facilities	eral Home nce Fred., MD20678 Approximate interval Between Onset and Death MMMMLS MMMMLS
Vital Records, P.O. Box 687	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physiclan/Medical	Part II. Other significent conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting in the unit of the conditions contributing to death but not resulting to death but not result not resulting to death but not resulting to death but not resul	Ectopic pregnancy Other (specify) Iderlying cause given in Part I. 23e. Did tobact 1 Yes 24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vit	ing Ph After th funeral	Certification; To Be	25. Was case referred to medical examiner? 1	28c. Injury at Work? M 1 Yes 2 No	n _t ury occurred t and Number or Rural Route Number,
•	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inverse and manner stated. 29b. Signature and whe of certifier	estigation, in my opinion, death occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Dey, Year)
8	ID Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, P James P. Jarboe, M.D. 31. Date filed (Month, Day, Year) 32. Registre's Signature	·	od, MD 20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day April 2004^{Year} **Physician** Julia Lagomarsini 5, 4:30 p M Pagan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chesapeake Beach Calvert 2296 Sansbury Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth
| Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Yrs. 64 19,1939 Puerto Rico Director 580-84-3903 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2296 Sansbury Drive 20732 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ¹♥Yes 2□No Specify:Puerto Rican Baltimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) school teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ Tanis Pagan Juana Lagomarsini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2296 Sansbury Dr., Chesapeake Beach, MD 20732 Joanne Ferreira, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Department of Important: If any injury or once. '4 Donation 5 Other (Specify) April 10,2004 La Piedad Cemetery Ponce, Puerto Rico 21 Signature of Funeral Service Livensee 22. Name and Address of Facility Wellast Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SARCOMA Physician - METRSTRTIC MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under vin Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed2 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar tu

Peter L. Wisniewski

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2004▶

32. Registras Signature

Station 1

D-40370

110 Hospital Rd. #310, Prince Frederick, MD 20678

April 7, 2004

Per la complete de la	3-40-265/ al Residence of Decedent State 10b. County ryland Frederic Street and Number 634 Motters Stat Marital Status Xelegation ong estreet and number) eation Road Sex 7. Age (In yrs. last birthday Yrs. 10c. City, Town or Lek Emmitsbur	4b. City, Town, or Location of Death ROCKY Ridge (1) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	2. Date of Death Month D March	Day Year 19, 2004 4c. County of Death Frederick ar) 9. Birthpla Country 9.22 Maryla	3. Time of Death 17:30	
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36	2 should be filed within 72 hours after death with the Maryland and Mentile Hygiene. Is marked other than "natural", or Items 23s or 28s-1 show sumatic event, the Medical Examinating the notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorce	12. Was Dec Armed For rried 1 TYPes If Yes, Gi	edent Ever in proces? 197	1956-		Hispanic Origin? an, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)		14. Rece - Ame Black, Whi	erican Indian,
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0	Dy ru	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 [X]Yes 2 [1] If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ဩ No	Specify:	ricali, etc.)		Black, Wh Specify:	Black
And b	ted	15. Decedent's E (Specify only highest gi	ducation	1,01	16a Deced	tent's Usual Occup	eation during most of work	ina	16b. I	Kind of Busines	s/Industry
1	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT use retired Carpenter	during most of work d)		Но	me Impr	ovement
		Ten Years 17. Father's Name (First, Middle, Las	1)			Jar pencer	18. Mother's Name	e (First, Middle	1	<u>.</u>	ovement.
٥	lo Re	Joseph	Lloyd				R	luth Har	milt	on	
	-	19a. Informant's Name/Relationship					and Number or Run				
		Vivian Lloyd (wi	fe)	20h B		-		Apt. 21	_		NY 11435
		20a. Method of Disposition 1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Speci		a	emetery, cren	sition (Name of matory or other place ational Cem	ce)			_ocation - City o verton,	New York
		21. Signature of Funeral Service Lice			L.	Name and Addre	ss of Facility	Son Fu	nera	1_Home,	P.A.
		23a. Pert1. Enter the disease, or cor	nolications that caused	t the death			e, Marylar			-0766	Approximate
ı		shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.			9,	,			Interval Between Onset and Death UNKNOWN
		disease or condition resulting in death)	aDue to (or as	G CAN a consequ					<u> </u>		UNKNOWN
I.		Sequentially list conditions,	b								
1.0	uluei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uerice of):						
1	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):						
			_ d	-							
18.6	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-				23d. Date of de	elivery
101	by Physician/Medical	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify)				Month	Day Year
9	y Ph	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco		to the cause of death?
1	ted							1 🗆	Yes 2	2 No 3 F	Probably 4X Unknown
	Completed							24a. Was auto perfe 1 🗆 Yes		death?	autopsy findings available completion of cause of second 2000 No.
	BeC	25. Was case referred to medical examiner?					26. Place of Deat				
F	2	1 ☐ Yes 2 X No			ER/Outpatier		4 Linuising no				ecify)
100	ation:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	Wor		28d. Describe	how inju	ury occurred	
1917	Certification:	3 Suicide 6 Could not determined		ury - At ho c. (Specif)	ome, farm, str	eet, factory, office		28f. Location (City or To	Street a wn, Stat	und Number or F te)	Rural Route Number,
- 0	edical C		hysician: To the best miner: On the basis o and manner st	f examina							
	20	29b. Signature and title of certifler	// <	1	/	29c. Licens	e number		29d. Da	ate signed (Mor	nth, Day, Year)
1	Ž		//	. 1111	7	- 400					
		March	a Blan	NIN	9	D428	300		APR	IL 5, 2	004

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiona

	State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Maryland / Department of Health and Message State of Department of Health All Message State of Department of Health All Message State of Department of Health All Message State of Department of Health All Message State of Message State of Department of Health All Message State of Message State of Health All Message State of He	entai Hygier Reg. N	Z11116 13037
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
/Medical			2004 1:25 PM 4c. County of Death
Examiner			
Funeral	Salisbury Nursing and Rehab Center Salisbury 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 18	B. Date of Birth (Month, Day, Yea	Wicomico 9. Birthplace (State or Foreign Country)
Director	579-58-1980 1□ M 2XIF 95 Yrs. Months Days Hours Min.	Sept. 13, 19	908 PA
p .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
ith the Marylan or 28a-1 show			1 ☐ Yes 2X No
with the Mar t or 28a-f si	MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code	10g, (Citizen of What Country?
uth with 23a or ust be real Dig	5 N. Pintail Dr. 21811		US
Sinfer death virtems 23s mins must	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri		14. Race - American Indian, Black, White, etc.
036 ours after death with the Maryla Fer; or frems 23a or 28a-f shov Exercipe must be rediffied at by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No HYes, Give 1 ☐ Yes 2 ☒ No Specify:	,	Specify: White
5-0036 72 hours after death with the Maryland naturel', or Items 23a or 28e-f show deal Examiner must be untified at effect by Funeral Director	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16h	Kind of Business/Industry
NRDO 21215-00 ed within 72 hou ygiena. ner then "nature it, the Medical E	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	9	, will of Buombourned by
SDC 212	Elementary/Secondary (0-12) College (1-4or 5+) I Homemaker		Own Home
Ind hill that tall Hyge of othe evant.	17. Father's Name (First, Middle, Last)		en Sumame)
J.EONARDC yland 212 yland 218 total bygiena. To Be Comm	I nomas Beaver Anna Li		
Maryland 21215-0036 d 2 should be filed within 72 hours alt th and Mantal Hygiena. Tris marked other then "naturel", or treumatic event, the Medical Exprint To Be Completed by F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural)		
C. L. C. L.	Donald Leonardo 5 N. Pintail Dr. Ocea 20a. Method of Disposition 20b. Place of Disposition (Name of Da	n Pines,	Md. 21811 Location - City or Town, State
ELSIE timore t Pages 1 triment of He	1 Surial 2 Cremation 3 Removal from State		entwood, Md.
ELSIE L. LEONARDO Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be illed within 72 hours after deal Department of Health and Mental Hygiena. Importent: If item 27 is marked other then "naturel; or items; eny pinury or other treumatic event, the Medical Examinet magnes. To Be Completed by Funer	21 Significative of Funeral Service Licenses 22 Name and Address of Facility		entwood, Ma.
Be pe me man man man man man man man man man man	The Burbage Funer 108 William St., Berl	in Md	21811
*	3a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. Use only one dause on each line.	respiratory arrest,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition ACUTE AEMAL FALVA		Onset and Death
/Medical Examiner	•		
	Sequentially list conditions, if any, leading to immediate b. A L 2++ E 1 ~ B ~ J Due to (or as a consequence of):		
nsit	cause (Disease or injury		
D, executed an and ial-transit	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
- 5 g 8 Q /	d		
c 687 c 687 ortificate I ing physi			
Box (Box certification of the	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
O. I he de the a	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	222-11	
Cords, P.O. Box wrequires that the death cert baan signed by the attendin should be detached for use	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds and sign and be		1 ☐ Yes	2 ☐No 3 ☐ Probably 4 ☐Unknown
of Vital Records, hysicien: The law requires the certificate has been signed director, page 2 should be to Be Completed by		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The late ha		performed	? death?
PPC I Vital ysicien: is certifica director, p	25. Was case referred to medical 26. Place of Death		
of V of N Fhysic ral dire	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outlet: 4 Nursing Hom		6 ☐ Other (Specify)
On o on o ding Ph	27. Manner of Death 28a. Date of Injury 28b. Time of 19 28c. Injury at 28c. Time of 19 28c. Injury at 19 28c. Time of 19 28c. Injury at 19 28c. Time of 19 28c	8d. Describe how in	njury occurred
isio	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28e.	Bf. Location (Street	and Number or Rural Route Number,
Division of tale or Attending P is after death. el Director: After ed in y the funer	4 Homicide determined building, etc. (Specify)	City or Town, St	ate)
the Hosp in 24 hou in E Fune pletely fil			
To the within Complex		ı	Date signed (Month, Day, Year)
	Politalla M.D. D29168	3	3/4/04
C.H.6	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBET ALEN, M-D, 1346 S. Division S	t Guita	Salisbury, Md.21804
State	31. Date filed (Month, Day, Year) 32 Registrar's Signature	c.suite/s	Ju Robury / Mu-21004
Registra	BEAT O COOL SEE OF COOLS		

		For Stata Registrar	State of Maryland		artment of H <i>rtificate of l</i>			iene	2004	13	038
1 To 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Decedent's Name (First, Middle, Last)					2. Date of Deat	h		3. Time of	Death
Physic /Medi		Melvin	J.	Mothe	ershead		March	Day 28	Year 2004	7:19	Рм
Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Dea	th	4c. (County of Death		
	E #	Waldorf Health Ca			Waldorf			Ch	arles		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day,	Year)	Coun		r Foreign
Director		577 05 1304	X 2 87	113.			Aug. 3,	191	6 Mary	Land	
land ow		10a. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside C	ty Limits
Many Frsh	to	Maryland Prince Ge	orge's	Fore	estville					1 🗌 Yes	2 110
h the	Directo	10e. Street and Number	.0181	1.01	10f. Zip Code		1	0g. Citiz	en of What Coun	try?	
death with the Maryland ms 23a or 28a-f show		6009 Druid P1	ace		20	747		Uni	ted Stat	es	
r dea	Funeral	The state of the s	Was Decedent Ever in U.S Armed Forces?	3. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	1	 Race - America Black, White, e 		
S afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 → No If Yes, GiveA A		1 ☐ Yes 2 ☐ No	Specify:			Specify:		
d 21215-0036 filed within 72 hours after Hygiene. sther than "natural", or Ite ent, Le Medical Examina		15. Decedent's Educ	Year or Dates:		A.A. dent's Usual Occup	ation		16b Kin	White		
in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of wo	orking		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	,	
Mith I with I with I with I with I with I with I will with I with I will with I	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	R	Receiving	Clerk		Sa	feway Bal	kery	
ITYIBNG 21215-0036 thould be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or tlems 23a or 28a-1 show matic event, the Medical Examinit must be multilised at	BeC	17. Father's Name (First, Middle, Last)	,			18. Mother's Na	me (First, Middle, M	Aaiden :	Sumame)		
	To E	William Mother	shead			Bet	ty Coates	S			
ar and and sm	ļ.,	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailir	ng Address (Street a	and Number or R	ural Route Number	City or	Town, State, Zip	Code)	
C = 14 F		Grace C. Mothersh				ace, For	estville,				
faltimore, rmit. Pages 1 a spartment of Heapportant: If item by injury or othe ICE.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	ace of Dispo metery, crer	sition (Name of matory or other plac	e) April	2. 2004		eation - City or To		
Firm Pag tment tant:		* 4 ☐ Donation 5 ☐ Other (Specify)			coln Ceme		Lee Funer		twood, Ma		ıd
Baltimol permit. Pages Department of Important: If i any injury or o	1	21. Signature of Funeral Service Ucense	0		Name and Address $33~01d~{\rm A}$		a Ferry R		P. 11)735
		23a, Part1. Enter the disease, or complic	MCOD 7 2-							Approximat	
8760, rate be executed messen by sician and the burial-transit the burial-transit the burial-transit messen by the burial-transit the burial-trans	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the total or as a consequence or as a consequence of the total or as a consequence of the total or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a	ыпса от).							
9 ∰ 6 %	Medi	IE EELAN E.						- p-			-
S, P.O. BOX 6. es that the death certific igned by the attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			2	3d. Date of deliver Month	•	Year
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ds urres d be	d b	MULTIPLE	SKIN UL	SAS			1 □ Ye	s 2 🗆	No 3□Proba	ably 4	Jnknown
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	Ö						4 🗆 🗸		I 🗀 Yes	2L NO	
E :: Eife	0	25. Was case referred to medical			-	26. Place of De		e)			
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			1- State of Maryland / Department Certificate Certificate	it of Health and M e of Death		ene 2004	13039
	Physicia	an	Decedent's Name (First, Middle, Last) ANNA ELIZABETH McGINNIS		2. Date of Death Month March	30°, 20°0°4	3. Time of Death 6:55 PM
	/Medic Examin			Town, or Location of Death	1102 011	4c. County of Death	1
			Genesis Eldercare 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	Plata	8. Date of Birth	Charl	
	Funeral Director		056-03-4174 1□ M 2X F 86 Yrs. Months	Days Hours Min.	May 3,	1917 Ne	place (State or Foreign ntry) York
	and aw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e-f she	ctor	MD St. Mary's Mechanicsvi	11e			1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28e-f show	Director	10e. Street and Number 26066 Cresent Lane 20066 Cresent Lane	Code 20659	100	g. Citizen of What Cou USA	ntry?
036	n 72 hours after death with the Marylan "natural", or leems 23a or 286-f show calcul Exercit at reast be recilled at	by Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	dent of Hispanic Origin? (Sp city Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
15-0036	"natur	leted	15. Decedent's Education (Specify only highest grade completed) (Give kind of wo.	al Occupation rk done during most of work se retired)	sing 16	6b. Kind of Business/Ir	ndustry
7.17	iene. iene. rthan	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Secre			IRS	
and	be filed tal Hyg d other svent,	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
5	2 should and Men Is marke eumatic	2	John Dikeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	Anna By (Street and Number or Run	rnes Di		o Code)
, Mar	7 1 1 2		Glenna Cox/Daughter 26066 Cr	esent Lane			•
Baltimore,	of H		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from State		L-04	c. Location - City or T	
	E 0 2		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M00817 22. Name an				
ñ	Departi Departi Import any inj ODCE		Fine Committee F.U.	art-Echols Box 567 La	Plata.	MD 2064	.A.
	Pnysician :	1 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				Ky in
	LAGIIIIICI	ē	if any, leading to immediate Due to (or as a consequence of):	Varirosci		3,	8.
	acuted ind transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	ST INFEC	YEDM,	1	K MICE
8/60,	cate be executed bhysician and the burial-transit	aiEy	resulting in death) Last Due to (or as a consequence of):				
٥	tificate ng phys	Aedicai	0.				
O. Box	that the death certificate be executed by the attending physician and detached for use as the burial-tra	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of deliv Month	ery Day Year
rds, P	The law requires that ate has been signed boage 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying contributions	ause given in Part I.	23e. Did tobad	cco use contribute to t	he cause of death?
II Kecords,		Completed			24a. Was an autopsy performe	24b. Were auto prior to co death? 1 \(\text{ Yes}\)	opsy findings available impletion of cause of 2 No
Vital	Physicien: Tribis certificarral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO		h (Check only one)	ce 6 ⊡Other (Specia	(v)
n of	ding Phys. h. After this funeral di	\vdash			28d. Describe how		7/
DIVISION	ten leat tor: the	icati	2 Accident investigation 3 Suicide 6 Could not be	1 □ Yes 2 □ No	28f Location (Stree	et and Number or Run	al Route Number
2	tel or Attend s after death al Director: , ed in by the f	Certification:	4 Homicide determined determined building, etc. (Specify)	, other	City or Town, S		a rosio rismoor,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred to the basis of examination and/or investigation; and manner stated.				
	To the within To the comp	M	29b. Signature and title of certifier 29c	Likense number	29	Date signed (Month,	Day, Year)
Μ	P2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)). WALK	Pons	mil 2	20103
	Sta Registr		31. Date filed (Month Pay Year) 2 2004 32. Refistrar's Signature	0			7

		Please	State of Ma				•		
		1 - For State Ragistrar	Otato or ma		ertificate of			eg. No. 200	4 13040
s3 ₽		Decedent's Name (First, Middle, Last))				2. Date of Deat	h	3. Time of Death
Physici /Media		Edward Br	ent	Maddox	Jr.		April	1, 2004	4:34 a M
Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of De	eth
		Fort Washington	Hospita	1	Fort V	Vashingt	.on	Prince	George
Funeral		5. Social Security Number 6. Se	D7	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) (rthplace (State or Foreign Country)
Director		577-68-8989 1L	A.W. Z.D.I	53 Yrs.			Jan. 1	6,1951 W	ashington [
and		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Mary f sh	ō	Maryland Charl	es	Bryans	Road				1 □ Yes 2X No
ith the Marylan or 28e-1 show	Funeral Directo	10e. Street and Number		<u>.</u>	10f. Zip Code		1	0g. Citizen of What 0	Country?
138 o	O E	6605 Pacer PLa	ce		206	16		U.S.A	•
death	nera	11. Marital Status	12. Was Decedent E	ver in U.S. 13	3. Was Decedent of H	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Am Black, Wh	
after or ite	F	1 ☐ Never Married 2 X Married	1X Yes 2 □ No	1971-	1 ☐ Yes 2 ☑No		o riloan, olo.)		
iral',	d by	3 Widowed 4 Divorced	Year or Dates:	1973				Specify: W	
natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dec	edent's Usual Occup re kind of work done . DO NOT use retire	pation during most of work	king	16b. Kind of Busines	s/Industry
within ane. than	m d	Elementary/Secondary (0-12)	College (1-4or 5+	-)				Hotel	
filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23s or 28s-1 show ent, the Medical Evantiner must be notified at		12 17. Father's Name (First, Middle, Last)			Carpente		ne (First, Middle, I		
buld be filed with Mental Hygiene. arked other the	To Be	Edward Brent M	Addox. S	r.		Betty	J.	Taylor	
2 should I and Men is marke	F	19a. Informant's Name/Relationship (T)			iling Address (Street	<u> </u>		, City or Town, State,	Zip Code)
1 2 2 4 2 4 2 4 4 4 4 4 4 4 4 4 4 4 4 4		Sandra Maddox	Wife	e 660!	5 Pacer	PLace,	Bryans	Road, Md	. 20616
s 1 a if Height Height		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla	C8)-a	Date	20c. Location - City o	r Town, State
Page nent o nt: If		1 ☐ Burial 2 【Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		Metropo	olitan F	uneral	Service	Alexand	ria, Virgin
permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other		21. Signature of Funeral Service Licens	%		22. Name and Addre	ess of Facility			
88 5 8		melanth	M	00668	Williams 4270 Haw	thorne 1	RdIn	dian Hea	d, Md.2064
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line a	consequence of):	enter the mode of dyn	ng, such as cardiac	or respiratory arre	failtr	Approximate Interval Between Onset and Poath
be executed sicien and burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):			V		
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	B⊟Ectopic pregnanc □ Other (specify)	у		23d. Date of do Month	elivery Day Year
quires that in signed t	þ	Part II. Other significant conditions co	ntributing to death but	t not resulting in the	underlying cause gr	ven in Part I.			to the cause of death? Probably 4 □Unknown
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ysici is cel direc	To B	examiner? 1 ☐ Yes 2 🔂 No	Hospital: 1 Inpatien	t 2 XER/Outpati	ent 3 DOA Ott	ner: 4 🗆 Nursing H	ome 5 Reside	nce 6 Other (Sp	ecify)
ng Ph ter th nerat		27. Manner of Death 1 □XNatural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time		ry at rk?	28d. Describe ho	w injury occurred	
Attending it death.	Certification;	2 Accident investigation]Yes 2□No			
I or Attendi after death. Director: A I in by the fu	THE LE	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injui building, etc.		street, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
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thin 2 the on the	Med	29b. Signature and title of certifier	and manner stat	ea.	29c. Licens	se number	. 2	9d. Date signed (Mor	nth, Dev. Year)
7 × × 8) 0 KX	1 (X W)	MV	1	20297	5	4-1-	04
		30. Name and address of person who d	implated eatise of de	ath (Item 23a) /Tuo	e Print)			7 /	
10.50+1VA	1	Daniel M. Howel				e Sauare	. Waldo	orf, Md.	20603
Sta	ate	31 Date filed (Month Day Year)	32. Rigistrai	's Signature	/ .4		,	,	
Regist		APR 0 7 2	UU4	4 S.	Cossell				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2 Date of Deeth 1. Decedent's Neme (First, Middle, Last) Dey **Physician** Miller Marv Elaine Ap<u>ril</u> 6 2004 9:15 AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Beverly Health Care Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Months Days Hours Min. Apr. 16, 19 9. Birthplace (Stete or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In vrs. lest birthday) 6. Sex **Funeral** 1 ☐ M 2X F 217-38-2854 73 Yrs. 1931 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County show permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylei pepermant of Health end Mental Hygiens. It is the pepermant of Health end Mental Hygiens if I flem 23e or 28e-1 show Important: If I flem 22 is merked other than "natural", or flems 23e or 28e-1 show any Injury or other traumatic event, the Medical Examines must be notified. Y Yes 2 No MD Frederick Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 30 North Place 21701 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Sfatus 1 ☐ Yes 2 ☐XNo If Yes, Give 1 XNever Married 2 ☐ Married Saltimore. Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ 3 Widowed 4 Divorced Yeer or Dates White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Pierre Sylvester Miller Elsie Sarah Armacost 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kurtis R. Miller - nephew 1 Phillips Lane, Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 4/8/04 Sykesville, MD 4 Donation 5 ☐ Other (Specify) 21. Signature i Furteral Service Livens 22. Nama and Address of Fecility Hartzler Funeral Home 6 E. Broadway, Union Bridge, Md. 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical End Stage Heart Disease yrs. Examiner Due to (or es e consequence of): Hypertension yrs. Examine attanding physiclen and for use as the buriel-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as e consequence of): Coronary Artery Disease yrs. Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): Chronic Obstructive Pulmonary Disease yrs. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cachexia, hypercholesterolemia, depression, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed renal insufficiency, cardiomegaly, osteoporosis completion of cause of death? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 28d. Describe how injury occurred Certification: 27. Menner of Deeth 28c. Injury at Work? 5 Pending investigation 1 🖾 Neturel deeth. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Director 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide or a 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

To the Hospital o within 24 hours af To the Funerel Di completely filled li

Cer 0

Allen Reilly, MD 31. Dete filed (Month, Day, Year)

29b. Signature and title of certifie

len

32. Registrer's Signature Alle No

801 Toll House Ave., D-1,

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

2004

29c. License number

D54749

Frederick, MD

29d. Date signed (Month, Day, Yeer)

April 6, 2004

21701

State

Registrar

	1 = For State Registrar		aryland / D	epartment of I Certificate of	Health and <i>Death</i>		giene 20	04 1304
Physician /Medical	Alliabett	e Mackley				2. Date of Dea Month April	3 ^{Day} 20	3. Time of Death 9:47A
Examiner Funeral	5. Social Security Number	pital Center 6. Sex 7. A	ge (In yrs. last birti	Wes		s. 8. Date of Birth		Carroll 9. Birtholece (State or Foreig
Director	220-34-6146 Usual Residence of Decedent 10a. State 10b. Cou	1 □ M 2 N F	65 Y	rs.		Dec. 14	, 1938	Mary land
or 28a-f sh	Maryland Ca	rroll		Un i OI	n Bridge		10g. Citizen of WI	1 ⊠ Yes 2 □ No
BAITIMOTE, IMATYIANG ZIZID-UU30 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinating must be notified at once. To Be Completed by Funeral Director	204 Pen 11. Marital Status 1 □ Never Married 2 ☑ N 3 □ Widowed 4 □ Divorce	If Yes, Give	7	13. Was Decedent of the Yes, specify Cub		Specify Yes or No- rto Rican, etc.)		A.A. - American Indian, White, etc.
Z IZ I D-UU30 ad within 72 hours al gjene. er than "neturel", or it, the Medical Exam Completed by F	15. Dece (Specify only hig Elementary/Secondary (0-1: 10	ent's Education hest grade completed) College (1-4or		Decedent's Usual Occu (Give kind of work dons life. DO NOT use retire homema	during most of word)	orking	16b. Kind of Bus	ness/Industry
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Daltimore, permit. Peges 1 a Department of Hes Importent: If item any injury or othe	*4 □Donation 5 □ Other 21. Signature of Furieral Servi	ca Licensee	Mounta	in View Cen 22 Name and Addr	ess of Facility	/6/2004 Hartzler Union Br	Funeral	Home
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ding Physical After this funeral di	examiner? 1 🗆 Yes 2 🗷 No	Hospital: 1 Impat 28a. Date of tnj (Month, Date)	urv 28b. Ti	me of 28c. Inju	her: 4 🗆 Nursing	Home 5 Reside		
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State	30. Name and address of pers	20 chusche	reath (tem 23a) (2005-e	inen H	e, wer	tumte	m 2004

			For State Registrar	State of Ma	ryland /	•	artment of H		and Men	tal Hygie	01	004	. 13	N.L
	Physici /Medic		1. Decedent's Name (First, Middle, Las Roosevelt	<i>t)</i>	N	lack	a11			Date of Death Month Dril	Day 8, 20	Year) () (4	3. Time of 0420	Death M
	Examin		4a. Facility Name (If not institution, give Calvert Memori 5. Social Security Number 6. Se	al Hospi	tal		4b. City, Town, or Prince	Frede	erick	Date of Birth	4c. County	1 ve	lana (State or	r Foreian
	Funeral Director				70	Yrs.	Months Days	Hours	Min. 0 (Date of Birth Month, Day, You Ct. 4, 1	933	Mar	yland	
	Maryland a-f show	μŞ	10a. State 10b. County aryland Calv	ert	10c. City, T	own or Lo	Hunt:	ingto	own				0d. Inside Cit	
	h with the	al Directo	10e. Street and Number 455 Ponds Woo	d Road			10f. Zip Code 20	639		10g	Citizen of V		ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar roust by notified at Once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ Wo	ispanic Origin, Mexican		Yes or No- n, etc.)	Blac	e · Americ k, White, ::B1a		
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natur the Medical I	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 54		(Give life.	dent's Usual Occupi kind of work done o DO NOT use retired O T e m a n	ation during most)	t of working		b. Kind of Bu		·	
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Mary	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relationship (7 Audrey Mackall				Ponds				ity or Town, ingto			0639
nore,	ages 1 arent of Hea		20a. Method of Disposition 1				osition (Name of matory or other plac neJones		Date 4 / 1 4 / 0	5.00	c. Location -		Bch.	.MD
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sion o			27. Manner of Death 1 Natural 5 Pending investigation		Year) 28	b. Time o Injury	f 28c. Injun Worl	y at	28d. No	Describe how	injury occurr	ed		
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filted in by	edical	(Check only 2 Medical Exam	ysician: To the best o niner: On the basis of and manner stat	examination		vestigation, in my o	pinion, dea		the time, date	and place, a	and due to	the cause(s)	
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_	ID		30. Name and address of person who 5 8 51 - Dec 31. Date filed (Month, Day, Year) APR 1	completed cause of de	ath (Item 23	Ba) (Type,	Print) GYA Road	N- T	e SI Deal	1RAN	D. O	207	1-1.	
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	Physici /Medio	cal	Decedent's Name (First, Middle, Las Hall Hall Hall Hall Hall Hall Hall	a B. M.	cken	nen	r Location of Death	April 3	Day Year 2004 4c. County of Death	3. Time of Death 3: 40 p M
	Funeral Director	le:	Calvert Memorial 3 5. Social Security Number 6. Social Security Number 1 216-34-8133 1 Usual Residence of Decedent		. last birthday) Yrs.	,	Frederic If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes		place (State or Foreign intry) cyland
	the Maryland 28e-f show colified at	rector	10a. State 10b. County MD Calve: 10e. Street and Number		ity, Town or Lo	Solor	mons	10g.	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
9600	72 hours after death with the Maryland 'naturel', or Items 23s or 28e-f show diest Exacifer must be rolliked at	Completed by Funeral Director	14624 Solomons I	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:		2068i Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:		Calvert 14. Race - Amer Black, White	ican Indian,
nd 21215-0036	filed within Hygiene. Ither then ont, I've Me	9	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work i) r, operat	ring	Kind of Business/Instaurant, en Sumame)	
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Baltimore,	permit. Pages 1 and Department of Heall Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Other (Specify.) 21. Signature of Fjuneral Service Licen	Sol	Lomons	esition (Name of matory or other place Church Ce 2. Name and Addres	em. 04-0		Location - City or T	
	de du de de de de de de de de de de de de de	W Y	23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. a.	th. Do not ent		g, such as cardiac	e, P.A., Poor respiratory arrest,	ort Repub	Approximate Interval Between Onset and Death
8760,	be executed ician and burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or as a consect Due to (or as a consect d.	quence of):					
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Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions or	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I.		use contribute to t	he cause of death?
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Division of Vi	tending Phys leath. tor: After this the funeral di	ertification; To B	examiner? 1 Yes 2 No 27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injury Work	er: 4 □ Nursing Ho vat c? Yes 2 □ No	me 5 ☐ Residence 28d. Describe how in	jury occurred	
Div	i g fe d	dical Certif	4 Homicide determined 29a. Certifier Certifying Physics	building, etc. (Special Special fy) owledge, death	occurred at the tim	ne, date and place,	28f. Location (Street and City or Town, Sta	(s) and manner as s	stated,	
	To the Hospitel within 24 hours a To the Funeral t completely filled	Medi	29b. Signature and title of gertifie	iner On the basis of examina and manner stated.	ation and/or in	29c. License	number	29d. D	ate signed (Month,	
	10		30. Name and address of person who	Galatra	(M.	Print) R	ince Free	derick,	MD	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 2004	32. Registrar's Signa	Spark	e				

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	Phỳsici	an	1. Decedent's Name (First, Middle, La	•						2	. Date of Deat Month	Day	Year	3. Time of Death	
	/Medic		BETTY	JANE		MAIN					1ARCH	20, 2		9:10 A	м
	Examin	er	4a. Facility Name (If not institution, given		1				rLocation of (erick	Death			unty of Deeth Freder:	i alz	
			Frederick Mem 5. Social Security Number 6. S			st birthday)		rreu 1 Year		Hrs. e	Date of Birth				ian
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			· Mill		14	D.		U.	264	99		3-	22-	04	
			30. Name and address of person who	completed cause of d	eath (Item	23а) (Туре,	Print)								
			Dr. Ronald Mille 31. Date fifed (Month, Day, Year)	2r, M.D. 32. Registra		well :	Dr.	Mt.	Airy,	Mar	yland	217	71		
	Sta Registr			3 2004 A	Signal	M	A.	rath s							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First. Middle, Last) Month Day Vear **Physician** Dorothy B. McAlister 19 2004 14:20pm March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner Montgomery Hospice Casey House Montgomery Rockville 8. Date of Birth (Month, Day, Year) Feb. 28,1921 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 ☐ M 2 🗆 XF Yrs. 83 Virginia Director 227-07-7231 Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23s or 28s-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State rthan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21771 26601 Mullinix Mill Road Funeral 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify Specify: ۵ White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event Be Maggie Mae Petty Charles M. Barfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Airy, Maryland 21771 2610 Mullinix Mill Road, Mt. Jeffrey McAlister/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 3/23/04 Rockville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Olin L. Molesworth P. A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complication in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final a Congestive Heart Failure months disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Diabetes Mellitus years physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 tha daath certificate be Physician/Medical Due to (or as a consequence of) as use use signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? cata has been sig 24a. Was an autopsy performed? Completed The law r this certificata has 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No funeral diractor, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death After 5 Pending investigation 1 XNatural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier whe le papal MD42452 March 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Chitra Rajagopal M.D. 18111 Prince Philip Drive #327 Olney, Maryland 20832 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar **DHMH 16 Rev 6/95**

MAR 2 2 2004

13048

			1. Decedent's Name (First, Middle, Last)		Time of Death
	Physiciat /Medica		Della Miller		l:30 p.m.
)	Examine		4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death	
			117 Main Street	Grantsville Garrett	_
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes Months Day	s Hours Min (Month, Day, Yeer) Country)	(State or Foreign
Á,	Director .		215-36-7888	July 15, 1913 Pennsy	Ivania
	fand		10a. State 10b. County 10c. City, Town or Location	10d. Is	nside City Limits
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5	Hyging the district of the dis	ပို	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)	1/110001
au	d be antal	To By	Christian W. Bender	Ida Hershberger	
Maryland	Shou man man	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	et and Number or Rural Route Number, City or Town, Stete, Zip Code	(e)
Ž	alth e 27 is		David I. Miller/son 9933 Rosedal	e-Milford Center Rd., Irwin, OF	H 43029
ore,	of He of He of He		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p	(ece) Date 20c. Location - City or Town, 9	State
<u> </u>	Page Int: #		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maple Glen Cemete	ry, March 17,2004 Grantsville,	, MD
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health end Marital Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Add	ress of Facility neral Homes, P.A., PO Box 275	
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	16/4	/	30. Name and address of person who pleted cause of death (Nem 23e) (Type, Print) Gary L. Wagoner, M.D., 925 Bishop Walsh Rd.,	Cumberland, MD 21502	
	State	2	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,	
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д О	res that the de signed by the a be detached f	Physician/Medi	9 Unknown										
	The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	by	Part II. Other significant conditions con	tributing to death bu	ut not resultii	ng in the un	iderlying cause give	n in Part I.		4	/		cause of death?
Ö	w require been si should b	eted	140.00						_ 1 🗆 Y	es 2	No 3[_ Probal	bly 4 Unknown
Vital Records,	: The law cate has b page 2 s	Completed							- 24a. Was autop	sy	prior	to com	sy findings available pletion of cause of
<u></u>										med? 2 No	deat	n? Yes 2	□ No
	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?	ospital:			Othe		Death (Check only o				
o	Physic this oral di	F- 1	1 Yes 2 No	1 Inpatier		VOutpatient Bb. Time of	I 3∐ DUA	4 Nursin	g Home 5 X esid 28d. Sescribe h			Specify)	
0	nding F th.: After funera	tior	Natural 5 Pending investigation	(Month, Day	Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 □ No	911-241-5				
Division of	of or Attending Physician: after death. Director: After this certification by the funeral director,	ertification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home	e, farm, stre	et, factory, office		28f. Location (S			r Rural I	Poute Number,
	s afte	Cert	4 Homicae	building, etc	с. (Бреспу)				City or Tow	n, State,			
	To the Hospitel or A within 24 hours after To the Funerel Direcompletely filled in D	edicai	29a. Certifier (Check only 2 Medical Examin	ician: To the best o	of my knowle	edge, death	occurred at the time	e, date and pla	ace, and due to the o	ause(s)	and manne	r as stat	ed.
	the H in 24 the F iplete	ledi	Unity	and manner stat	ted.		estigation, in my op	mion, death of	couried at the time, o	ate and	piace, and	due to ti	ne cause(s)
	To To con	Σ	29b. Signature and title of certifier	1			29c. License		2		signed (M	1	ay, Year)
			Culturas	a seculo			D36	644		3-	11-01	<u>+</u> _	
		1	30. Name and address of person who con				,						
	Sta	10	John Mastandrea, M 31. Date filed (Month, Day, Year)	.D. 509	Idlew	ild A	venue Eas	ston, M	aryland	2160	1		
	Registr	_	MAR 1 1 2	004	Gibber S	B. A	12246						

			_ For	State of Marylan		ment of Health and I	Mental Hygien	ie o o o i	1
			1 - State Registrar		Certif	cate of Death	Reg. N	io. 2004	13050
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last) DORA WILLIA Ag. Facility Name (If not institution, give s	MS MITC	HELL	. City, Town, or Location of Death	2. Date of Death	- 2004	3. Time of Death
	LAdiiii	CI	CARDLINE NUR:	SINGHOME	\equiv I	DENTON	(CARDL	INE
	Funeral Director		5. Social Security Number 6. Sex 182-24-3418A	7. Age (In yrs.)		Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Yea 04-21-	9. Birti 131	hplece (State or Foreign
	death with the Maryland ims 23s or 28s-f show	ctor	10a. State 10b. County CAROL		y, Town or Location	on V			10d. Inside City Limits 1 Yes 2 □ No
	th with the 23a or 28	Funeral Director	240 MAIN S	TREET	1	01. Zip Code 21655	10g. C	Citizen of What Co	untry?
036	be filed within 72 hours after death with the Marylan stal Hygiene. Ind Hygiene. Indoorder than "natural", or itams 23a or 28a-f show event, tra Mudical Eventance ovent, tra Mudical Eventance or the profiled at	by	11. Marital Status 1: Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Ye	Decedent of Hispanic Origin? (S.s. specify Cuban, Mexican, Puert Yes 2 No Specify:	Decify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - Amel Black, White Specify:	
21215-0036	within 72 ho ene. than "natur to Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give kind life. DO f	s Usual Occupation of work done during most of wor (OT use retired)	king	Kind of Business/I	Industry VTING
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than eumaltc event, It a Mu	To Be C	17. Father's Name (First, Middle, Last) HARRY LEON M	ITCHELL			RUMBO		
	s 1 and 2 should of Health and Men Item 27 Is marks other treumatic		19a. Informant's Name/Relationship (Ty)	R. (POA)	19b. Mailing Ad 110 FR lace of Disposition	ANKLIN STRI	ET DEN	TON, M	10 21629
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		emetery, cremato DITAI (ry or other place)	11/04 D	Location - City or T	DE
Balt	permit. Page Department of Importent: If any injury or ance.		21. Sign tun of Funeral Service License	96	22. Na WIL 311	me and Address of Facility LLAMSON FUN S. MAIN 577	JERAL HO	MESAL	21637 BURG, MD
· ·	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Metasta Due to (or as a consequ	tic 2		or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	cate be executed only sician and the burial-transit	ical Examiner	Sequentially is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	, 				
P.O. Box 68	the death certific y the attending p Iched for use as	Physician/Medi	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ect	opic pregnancy er (specify)		23d. Date of delin Month	very Day Year
	signed be del	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the under	ying cause given in Part I.	23e. Did tobacco	_	the cause of death?
al Records,	The ate h page	Completed					24a. Was an autopsy performed? 1 □ Yes 2 □ N	prior to c death?	opsy findings available ompletion of cause of
of Vital	Physicien: Tribis certificate rate director, p.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3	04	th (Check only one) ome 5 Residence	6 ⊟Other (Spec	ifv)
ion of	Attending Physic death. ector: After this by the funeral di		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju		
Division	o it e	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify			28f. Location (Street a City or Town, Sta	te)	
	To the Hospitel within 24 hours a You the Funerel Completely filled	edical	29a. Certifier (Check only one) (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occition and/or investig	urred at the time, date and place, gation, in my opinion, death occur	and due to the cause(red at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
)	To the To the comp	W	29b. Signature and title of certifier	Secon	1	29c. License number 29./376		ate signed (Month)	
			30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, Print	P3/376 Ket St	Doite	11 145	2220
i	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture		VENU	10 110	01621

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I			giene 1eg. No. 200	1305
	Physici	an	Decedent's Name (First, Middle, Land CAROLYN SU					2. Date of Dea		3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, gi	ve street and number)			or Location of Death		4c. County of Dear	
14 V	Funeral Director			Sex 1 M 2	e (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 20	, Year) Co	thplace (State or Foreign puntry)
	Maryland a-f show	tor	MD 10b. County Caro	line	10c. City, Town or Lo	ocation	Prestor	n		10d. Inside City Limits ∰Yes 2 □ No
	ath with the Maryla 23a or 28a-1 show	Funeral Director	10e. Street and Number 151 North Mai	n Street		10f. Zip Code	21655		Og. Citizen of What Co	_
036	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examinative unit be inclified at	þ	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of his fixes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:		14. Race - Ame Black, Whit Specify: W	encan Indian, e, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after des Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items any injury or other traumatic event, Ite Medical Examination.	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire eteria	during most of world)	king	16b. Kind of Business,	
yland	should be filed and Mental Hyg s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Las Ū (1 k r) O W r)	<i>(</i>)			Ellen M	lerritt	Maiden Sumame) Compton	·
	s 1 and 2 shu f Health and item 27 is m other traum		19a. Informant's Name/Relationship Darcey McMahan 20a. Method of Disposition		P.O.	Box 10:	3, Prest		r. City or Town, State, 2 r. v. 1 and 21 20c. Location - City or	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	fy)	Jr.Orde		ery 3/27		Preston, Funeral 1	
Ä	Dermi Depa Impo any is	5 7	23a. Part1. Enter the disease, or cor	onlications that caused	2	l6 North	h Main S	t., Fed	eralsburg	, MD 21632
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Metas Due to (or as	a consequence of):	Lung	Cano			Interval Between Onset and Death
8760,	law requires that the death centificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit.	dical Examiner	Esquentially list son discons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence of):					
P.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death 3	Ectopic pregnancy	y		23d. Date of deli Month	very Day Year
	w requires that the state of th	ted by Pt	Part II. Other significant conditions Colombia	contributing to death b	- 1	nderlying cause giv	ven in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
of Vital Records,	The ate h page	Completed by	Hyperteras	in				24a. Was a autops perform 1 🗆 Yes 2	y prior to c	topsy findings available completion of cause of 2 No
of Vit	Physician: r this certificatal director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatie			4 U Nursing Ho		e) nce 6 □Other (Spec	cify)
Division o	ling After	Certification:	27. Manner of Death Natural 5 Pending investigation Accident Pending investigation Suicide 6 Could not be a course	A	Year) Injury		yat rk? Yes 2 □ No		w injury occurred	
Div	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	building, etc				City or Town		
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	29a. Certifier (Check only one) The Certifying P	hysician: To the best of miner: On the basis of and manner sta	examination and/or in	occurred at the tire of the street of the st	me, date and place, ppinion, death occur	and due to the ca red at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
	with To	Σ	29b. Signature and title of certifier	Delm	LHD	29c. Licens	3602	29	3/23/04	Day, Year)
200			Dr. Carolyx	Helmely.	eath (Item 23a) (Type,	Print) tchmans	Lane	Easton	, md. 2	1601
	Sta Registr		31. Date filed (Month, Day Year) MAR 2 5	32. H egistra	ar's Signature	Conto	Lane,			

			State of Maryland / Department of Health and M 1- State Registrer Certificate of Death	lental Hygie	_	13052
			Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physici		John Wayne Miller	April	4 2004	10:55 P M
	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Deatl	
			Harford Memorial Hospital Havre De Grace	and the state of t	Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign untry)
	Director		220-40-9413 1X M 2 F 61 Yrs. Mornins Days Hours Min.	8. Date of Birth (Month, Day, Ye August 3	31,1942	MD
	Pu ≥		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	death with the Maryland ms 23s or 28e-f show	7				1 ☐ Yes 2 No
	N he N	Director	MD Cecil Rising Sun	140	63:	
	with t	급	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?
	eath is 23	Funerai	464 Harrisville Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spi	noify Yea or No	USA 14. Race - Amer	nean Indian
10	ter d	Š	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ ★No	Rican, etc.)	Black, White	
7	J36	by	If Yes, Give 1 ☐ Yes 2 ☐XNo Specify: 3 ☐ Widowed 4 ☒ Divorced Year or Dates:		Specify: Wha	ite
30.3	1215-0036 within 72 hours after then "netural; or te	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	. 16b	. Kind of Business/I	ndustry
3	212 Fig. 1	ple	(Specify only highest grade completed) (Give kind of work done during most of work) [Flementary/Secondary (0-12) College (1-4or 5+)	ng		
	21 w bg will will be a true of the true of true of true of the true of true of true of true of true of	Completed by	8 Fabricator		Brick Fat	rication
	be file d oth event	Be ((First, Middle, Maid	ien Sumame)	
士	Vla Suld b Ment Ment arked	2	Robert W. Miller Lillian	1 Jones		
4/4/04	Maryland 21215-0036 Id 2 should be filed within 72 hours after dea tit and Mental Hygiene, netural; or tems '1's marked other than "netural; or tems 'traumatic event, tre Marical Examinations."		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		•	
7	and and ealth m 27		Mary L. Stanton/Companion 464 Harrisville Road			
	Ore Jes 1 of H if ite		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	-2004	. Location - City or 1	Town, State
-1	Pag ment ment tant:		"4 □ Donation 5 □ Other (Specify) R.T. Foard Funeral Home, P.		Rising Su	in, MD
	Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licensee for Jorde 22. Name and Address of Facility R.T. 111 S. Queen Street	. Foard F , Rising	uneral Ho Sun, MD 2	me, P.A.
pl			23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cayse on each line.	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death
_	/Medical		resulting in death) Due to (or as a consequence of):			
8	Examiner		sometime in End Stage CHF			
	n =	ner	Sequentially list conditions, if any, leading to immediate rause Enter underlying Due to (or as a consequence of):			
Z	nd nd transi	Examiner	that initiated events c. Live CA			
2	760, te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):			
2		lical	a Lung CA	· · · · · · · · · · · · · · · · · · ·		
3	4 68 ertifica ling ph	Physician/Med	IF FEMALE:			
8	30)	lan/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliv	very Day Year
\leq	o de de an the an hed fe	Sic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown		North	Day .ca.
	P.C		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did tobaco	o use contribute to	the cause of death?
	d be d	Þ.	Tarris, Otto Significant Contacting to Country to Country in the United Hydrographic Country are in	1 ☐ Yes	. /	bably 4 \(\bar{\pi}\)Unknown
5	Record The law require the has been si age 2 should I	Completed		-	2200 00:10	
0	e 2 s	du		24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
1	The cate	S		performed	death?	2 🗆 No
	of Vital Physician: rthis certifica	Be	25. Was case referred to medical examiner? Hospital: Unaview of Death Other:			
	Phys this al dir	2	1 inpatient 22 EH/Outpatient 3 DOA 4 Nursing Hor	me 5 Residence		ify)
	Jing Jing After funer	0	Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how in	ijury occurred	
	ision then death ctor: / the	cat	3 Suicide 6 Could not be	28f. Location (Street	and Number or Rus	al Poute Number
	Division of Vital to a variation of Vital and to Atlanding Physician: Tafter death. Director: After this certificat d in by the funeral director, pa	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, St	ate)	ar mode reamber,
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	edical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	o the ithin ? o the omple	Mec	29b. Signature and title of certifier 29c. License number	29d. [Date signed (Month,	Day, Year)
	F ≥ F 8		Internal Medica DANGO 76		4/5/04	
					1-/	
0	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) No khada 38 E. Main St. Ris	sina Su	O.MD	21911
	Sta	ite	31. Date filed (Montin, Day, Fear) SE. Hegistrar's Signature	Ü	1 1	
	Registr		APR 0 6 2004			

			For State Registra AMEND TIEM #26	State of Marylan PER PHY C831 5/00	d / Depart 3 /04 ^{de}rti i	tment of H	ealth and Death		giene Reg. No.	2004	13053
	Physici	an	1. Decedent's Name (First, Middle, Last) Woodrow Wil					2. Date of De. Month Mar.	26,	2004	3. Time of Death 12:02 A
	/Medic Examin		4a. Facility Name (If not institution, give s 9215 Baltimore	treet and number)	4	b. City, Town, or Middl	Location of Dea		4c. 0	County of Death Freder	1
	Funeral Director		213 30 01 10 1	7. Age (In yrs. 62		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year)	1941°	pplace (State or Foreign untry) MD
	Maryland -I show	tor	Usual Residence of Decedent 10a. State 10b. County MD Freder		y, Town or Local	ddletow	7 n				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	i Direc	10e. Street and Number 9215 Baltimore	National P	ike	10f. Zip Code 2176	59			en of What Col	untry?
396	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or tems 23a or 28a-f show odher than "natural", or tems 23a or 28a-f show event, the Medical Exaft, and must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3√□ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			spanic Origin? (n, Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)		4. Race - Amer Black, White Specify: Wh	
21215-0036	within 72 hou ene. than "nature he Medicul E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give kir life. DO	nt's Usual Occupa nd of work done of NOT use retired,	luring most of wo	orking	ro1	d of Business/l 1 on ucking	
land 2	should be filed nd Mental Hygi marked other umatic evant, I	To Be Co	17. Father's Name (First, Middle, Last) Woodrow W. Mi	ller Sr.	J. 121		18. Mother's Na	me (First, Middle, Kathryı			
Maryland	C 62 55 65	1 35	19a. Informant's Name/Relationship (Ty Oneida Hartley		19b. Mailing 9215	Address <i>(Str</i> eeta Baltimo	and Number or A ore Nat	ural Route Number	Pike	, Midd	lletown,
Baltimore,	Pages 1 and 3 nent of Health int: If Itam 27 iry or othar tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Spacify)		Place of Disposition of the Communication of the Co	ion (Name of tory or other place Cemete	ery 3/2	Date 29/04		rsvill	
Balti	permit. Pages. Department of h Important: If Its any injury or of once.		21 September of Funer Service Livens	24	31	E. Maj	n St.	son Fui Middle	etow	1 Home n, MD	21769
	Pnysician /Medical Examiner		23a. Part Epper the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat le cause on each line.	cal CAN	the mode of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury	Due to (or as a consec	quence of):						
8760,	cate be executed physician and the burial-transit	Ical	that initiated events resulting in death) Last	Due to (or as a consect.	quence of):						
.O. Box 6	death certifi e attending ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of continuous 1 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	eldeath 3 🗆 E	ctopic pregnancy Other (specify)			2	3d. Date of deli Month	very Day Year
ds, P.	quires that n signed b uld be deta	b	Part II. Other significant conditions co	ntributing to death but not res	sulting in the und	erlying cause give	en in Part f.	23e. Did t		/	the cause of death? bably 4 ☐Unknown
al Records,	ian: The law requires that the rdificate has been signed by th stor, page 2 should be detache	Completed						1 ☐ Yes	psy ormed? 22 No	prior to death?	topsy findings available completion of cause of
Vital	.≅ 8 €	o Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2] ER/Outpatient	3□ DOA Othe	or.	eath <i>Check only</i> Home 5 V Resi		□Other (Spec	eifv)
of		on: To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	y at k?	28d. Describe			,
Division	or Attancater death	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci			Yes 2 □ No	28f. Location (City or To		l Number or Ru	ral Route Number,
_	Hospita 24 hours Funaral tely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Examination	sician: To the best of my kn- ner: On the basis of examina and manner stated.	owledge, death o ation and/or inve	occurred at the tin stigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	steted. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	norde		29c. Licenson	307		29d. Date	signed (Month	n, Day, Year)
	12		30. Name and address of person who	ompleted cause of death (Ite	m 23a) (Type, Pr ME DI			ELEBER	ECT	Na	21701
	St	ate	31. Date filed (Month, Day, Year) APR 0 1 2	32. Registrar's Sign	ature	and he			,		

	95 OS		1 = For Amend & Unpend I	State of Ma				Mental Hyg	iene	nde.	13054
	Physici /Medi	cal	·	McLead, Jr.		4h City Town or	r Location of Death	2. Date of Dea Month March 2	Day 200		3. Time of Death
	Examir	ner	4a. Facility Name (If not institution, give: Shady Grove Adver. 5. Social Security Number 577-27-4115 6. Sec	tist Hosp	ital (In yrs. last birthday) 9 Yrs.	ROCKVI If Under 1 Year Months Days		8. Date of Birth		gomer	Y ece (State or Foreign try)
	Director	J.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo		- 11:11 -	PARCI 20	, 1993		ington, D.C. Od. Inside City Limits 1 ☐ Yes 2 □ No
	th with the M 23e or 28a-f	ai Directo	Maryland Prince Geo 10e. Street and Number 6001 St. Moritz Dr)2	10f. Zip Code	e Hills 20748	1	0g. Citizen of	What Coun	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-f show other traumatic event, the Mudical Examiner rate by riviling an other traumatic event, the Mudical Examiner rate by	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Bla	ce - America ck, White, e Black	
21215-0036	filed within 72 ho Hygiene. other then "neturent, the Madical	ompleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired Sturlent	ation during most of work ()	ring	16b. Kind of B		
Maryland	2 should be filed and Mental Hygid Is marked other surnatic event, II	To Be C	17. Father's Name (First, Middle, Last)	McLead, Sr.	19h Mailir	ng Address (Street	18. Mother's Nam	Michelle	Bridges	3	Code
	gges 1 and 2 s of Health ar if Item 27 is or other trau		Mr. Dwayne M. McLeod, S 20a. Method of Disposition	Gr. (Father)	6001 S 20b. Place of Dispo cemetery, crei	St. Moritz 1 sition (Name of matory or other place	Drive Art.	#302 Temp1	e Hills, 20c. Location	Maryl City or To	and 20748 wn, State
Baltimore,	Mr. Dwayne M. McLeod, Sr. (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of cometery) 20c. Loc Cometery April 5, 2004 Clints 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4339 HNT PLACE, N.E. WASHINGTON, D.C.										m.
	Physician /Medical Examiner	Examiner	23a Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a Anomalous	0.0000000000000000000000000000000000000			or respiratory arri	est,		Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exar	(F.FEMALE:	Due to (or as a did. 3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			I .	te of deliver	y Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob		nbute to the	e cause of death?
Vital Rec		Be Completed	25. Was case referred to medical				26. Place of Deat		y ned? 2 No	prior to com death?	sy findings available apletion of cause of
ot	ng Ph Iter th Ineral	ြ	27. Manner of Death 1 Natural 5 Pending 24. Accident investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury Work	er: 4 Nursing Ho	ome 5 🗌 Reside 28d. Describe ho	nce 6 □Oth	_ ' ' ' ')
Division	Hospital or Attendi 24 hours after death. Funeral Director: A itely filled in by the fu	d Certification:	3 Suicide 6 Could not be determined	building, etc.				28f. Location (St. City or Town	, State)		
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2D Medicel Examination one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	vestigation, in my op 29c. License	oinion, death occur e number	red at the time, da	ate and place, 9d. Date signe March 2	and due to	the cause(s)
	Sta	ite	30 Name and address of person who con the light of the li	ICA-KOU	AKMIK) 111 Pe	nn Street	, Baltin	nore, M	aryla	nd 21201
	Registi		APR 0 5 20	04	s Signature	mosses					

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrar AMFND TTFM #19a g830 4/26/04 JH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Villian Month Day 2004 April /Medical 1:45 p 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Asbury Solomons Health Care Solomons Calvert 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or ruleig Country)
Feb. 13, 1920 Washington, DC If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1√2 M 2□ F Director 216-12-4971 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28e-f show r than "natural", or items 23e or 28e-f show The Madical Exertiner must be potified at 1 ☐ Yes 2 ☐ No Director Maryland Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2824 Beach Drive death Funeral 20639 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Serves 2 No If Fes, Give Year or Dates: 1943-45 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify ð Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 electrician I.B.E.W. 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental Alvin B. ပ Newton Lera Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MINNETTA HINTEGA B. permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 ts any injury or other trau Newton, wife 2824 Beach Dr., Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Emmanuel Cemetery Apr. 9,2004 Huntingtown, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility elloul Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ever moving /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 2 or Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To this erel Director: After th filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Matural Accident 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel Completely filled Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10052242 05 0 30. Na - and address of person - o completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

J.John Barth III,

31. Date filed (Month, Day, Year)

M.D.

APR 0 7 2004

32. Registre's Signature

110 Hospital Rd. #310, Prince Frederick, MD 20678

			Please I			ible ink. Ensure	•		
			For	State of Marylar		nent of Health and	Mental Hygie	ene 2001	1000-
			1 - State Registrar		Certifi	cate of Death	Rag	I. No. CUUL	13051
			1. Decedent's Name (First, Middle, Last)			,	2. Date of Death Month	Day Year	3. Time of Death
	Physic /Medi		Willie	Henry	1 Ne	al	April	06, 2009	4 9:30 PM
	Exami		4a. Facility Name (If not institution, give s		4b.	City, Town, or Location of Dea	ath	4c. County of Death	
			Chesapeak	e Woods		Cambridge	0	Dorch	ester
	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs.		Under 1 Year If Under 24Hr nths Days Hours Mir	8. Date of Birth (Month, Day, Y	9. Birth	place (Stete or Foreign
	Director		1220-26-8088 18	M 2□F 70	Yrs. Mc	nuis Days Hours Smir	Aprilol	1925 1-	Torida
	pu ,		Usual Residence of Decedent						
	aryla shov	_	10a. State 10b. County		ty, Town or Locatio	n ,)			10d. Inside City Limits
\bigcirc	Ba-f	cto	MD Dorch	ester		ridge			1 PYes 2 No
R	or 2	Director	10e. Street and Number		11	Of. Zip Coo	100	. Citizen of What Cou	ntry?
3	d within 72 hours after death with the Maryland yiene. rthan "natural", or items 23a or 28a-1 show the Medical Examine must be notified at		725- CORNI	Sh DRI	ve	2/6/3		45A	
6	r de:	Funeral		Was Decedent Ever in L Armed Forces?	I.S. 13. Was	Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
98	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		es 2 No Specify:		Specify: A	
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21215-0036	nat nat	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give kind	Usuat Occupation of work done during most of w	orking 16	ib. Kind of Business/Ir	ndustry
12	within ene. then the	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		OT use retired)	-		T 1:
2	filed with Hygiene ther the	ပိ	17. Father's Name (First, Middle, Last)		CRan		ame (First, Middle, Ma	erT. I. Zei	RINdustry
ŭ	d ta b	Be		1001					
Š	should but marked marked	2		leal	100				nknown)
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Typ	1.	19b. Mailing Ad	dress (Street and Number or F	Rural Houle Number, C	city or Town, State, Zi	Code)
	1 and 1 ealt 9 m 2		20a. Method of Disposition	Kane	Place of Disposition	Kose Mont 141	Date 20	dge, M.	0.01613
ō	ges it of l		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		cemetery, cremator	y or other place)		c. Lozalioz - City or T	own, State
Ë	Pag Iment Iant: I	ļ	*4 □Donation 5 □ Other (Specify)		augh C	emetery 14/	10/04 C	imbridge	MD.
Baltimore	Departing Imports any in a		21. Signature of Funerat Service License	° 7/2	22. Na	me and Address of Facility	Home, P.	A. J	
=	707 4 0		Johnelle	C. Henry	\$ 510	way Funekul washington	st. Cambi	idge, MD	121613
			23a. Part1. Enjer the disease, or complice shock of heart failure. List only on	cations that caused the dea e cause on each line.	Do not enter the	mode of dying, such as cardia	ac or respiratory arrest	. 07	Approximate Interval Between
М	Physician		tmmediate Cause (Finat disease or condition	Arterios	clerolic	Cordiovaculer	difeese		Onset and Death
AL.	_/Medical		resulting in death)	Due to (or as a consec	juence of):				1
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	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (ur as a consec	aence of):				
	te be executed ysician and ie burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
ó	an a		resulting in death) Last	Due to (or as a consec	uence of):				
1760,	ite be iysici ne bu	cai	d						
68	that the death certificate ed by the attending phys detached for use as the	Physician/Medi						1	
Вох	h cer endir r use	Z.	23b. was decedent pregnant	Bc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		pic pregnancy		23d. Date of deliv	ery
	deat le att	icle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of c		er (specify)		Month	Day Year
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	The law requires that the ste has been signed by the bage 2 should be detache	ру Р	Part II. Other significant conditions conf		ulting in the underly	ring cause given in Part I.	23e. Did tobac	co use contribute to t	ne cause of death?
ğ	quire en siç uld b	ed	Den	ieu ha			1 ☐ Yes	2 □ No 3 2 Prol	oably 4 Unknown
Division of Vital Records,	s bee	Completed					24a. Was an	24b. Were auto	opsy findings available
Re	The ta	шо					autopsy performe	prior to co death?	mpletion of cause of
tal	iffical		25. Was case referred to medical			00 Pinns 4 Pa	1 ☐ Yes 2 ☐	No 1 □ Yes	2) No
5	sicis s cert lirect	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐	EB/Outpations 3	Ta.	ath Check on on		
o	Phy or this		27. Manner of Leath	28a. Date of trijury	28b. Time of	28c. Injury at	Home 5 ☐ Residence		<i>y</i>)
o	ding th. : Afte	Ę.	1 Aatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	Injury M	Work?		,	
<u> S</u>	Atter dea ctor y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, street, fa	actory, office	28f. Location (Stree	et and Number or Rura	al Route Number
Ö	after Dire	Certification;	4 Homicide	building, etc. (Special	y)	,,	City or Town, S	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Cartifying Phys	ician: To the best of my kno	wledge death occi	urred at the time, date and plac	e and due to the caus	e(e) and manner as e	tated
	24 h 24 h e Fur etely	edical	(Check only 2 Madical Examin	ar: On the basis of examina and manner stated.	tion and/or investig	ation, in my opinion, death occ	urred at the time, date	and place, and due to	the cause(s)
	ompl	Me	29b. Signature and title of certifier	-01		29c. License number	29d.	Date signed (Month,	Day, Year)
	- s + ō		Naug	evy MD		D 47924		4.8-04	
			30. Name and address of person who cor	<u> </u>	23a) (Tues Delet				
			NOMAN THANNY	300 AU	23RA SI	REET CAMI	BRIDGE	MD 2	16/3
	Sta	te	31. Date filed (Month, DayA) PR 0 8	32 Registres Signa	iture	1			- / /
	Registi		HER OC	ZUU4) Blown	15 B	out			

State of Maryland / Department of Health and Mental Hygiene200113058 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2, Day 2004 ear **Physician** 7:10 PMM Ralph Edward O'Bier /Medical 4a Fecility Name (If not institution, give street and number)
Civista Medical Center 4b. City, Town, or Location of Death 4c. County of Deeth Examiner LaPlata, MD Charles ff Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1X M 2□F Director 62 217-36-9771 1941 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or Items 23s or 28s-f show other treumatic event, the Modical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Charles Waldorf Direct 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 12793 Waldorf Forest Road 20601 Funeral filed within 72 hours after death United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whife, etc. 11 Marital Status 1 ☐ Never Married 2 X Married Yes 2 No 1 ☐ Yes 2 💢 No Specify: þ Specify 3 Widowed 4 Divorced "naturef" Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Colfege (1-4or 5+) 9 Electrician Construction 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filt ment of Health and Mental H; tent: If item 27 ie marked oth 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Edward O'Bier Rosie Muriel Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris O'Bier-wife P.O. Box 1484, Waldorf, MD 20604 timore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 permit. Page Depentment Importent: If any njury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 04-03-2004 Waldorf, Maryland <u>Huntt_Crematory</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01246 Nack A. Lidilyon Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Vaccul Immediate Cause (Final **Physician** disease or condition resulting in death) 2 x DAW /Medical Due to (or as a consequence of) Examiner OBSTRUCTINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit equires that the death certificate be executed NOTONOSO that initiated events resulting in death) Last Due to (or as a cons Division of Vital Records, P.O. Box 68760 Physician/Medical NSUFFI 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetef death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant af time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ IABES IS, MELLETHI. 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed CHYMNE LEVING DESINGE. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe HrungeryTupeNIA 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 papatienf 2 EP/Outpatienf 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funerei Director: After Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🏂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date sigged (Month, Day, Year) D-20629 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George H. Wathen, MD 11345 Pembroo Wathen, MD 11345 Pembrooke Squ., Suite 103 Waldorf, MD 20603 MP 31. Date filed (Month, AP Kear) 6 2004 32. Registrar's Signature State Jen. Registrar

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			1 _ State	State of Mar	ylanu	•	rtificate				2	nn.	100	100
			Registrar 1. Decedent's Name (First, Middle, Last)			06	Tillicate C	JI Deall	11	2. Date of De	Reg. No.	004	3. Time of D	15 y
	Physici	an		(7.1	10.40					Month	Day	Yeer		
	/Medic		4a. Facility Name (If not institution, give str		(enc)		4b. City, Tow	m or Location	n of Death	- 1	45 COU	nty of Death	1730	
4	Examin	er		-Mn-S	leat.	1	40. City, 10W	12						
			5. Social Security Number 6. Sex		In yrs. las	t birthday)	If Under 1 Ye		er 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birtho	place (State or I	Foreian
	Funeral Director			v 2□F 51		Yrs.	Months Da	ys Hours	Min.	(Month, Da	y, Year) 24 , 1951	2 Ar	izona	
			Usual Residence of Decedent				l			осре.				
	nylan how		10a. State 10b. County	1	10c. City, 1	Town or Lo	ocation] 1	0d. Inside City	
	a-f s	cto	Maryland Cecil					E1kto1	n				1 Tyes 2	! [X] NO
	ih th	Oire	10e. Street and Number				10f. Zip Cod				10g. Citizen		ntry?	
	ath w	by Funeral Director	169 Old Chestnut F					21921				.S.A.		
	er de	une	TT. Warter Olates	2. Was Decedent Ev Armed Forces?		13.	Was Decedent If Yes, specify (of Hispanic C Cuban, Mexic	Origin? (Spe can, Puerto	cify Yes or No Rican, etc.))- 14. F	Race - Americ Black, White,		
36	s afte	Ϋ́	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			1□Yes 2🗓	No Specif	ty:		Spe	ocity: W	hite	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene do the than "naturel", or items 23a or 28a-f show of other than "naturel", or items 23a or 28a-f show event, I'm Medical Evantinal must be notified at		15. Decedent's Educa		[.	16a. Dece	dent's Usual Oc	cupation			16b. Kind o	f Business/In		
5	in 72 n n	olet	(Specify only highest grade	completed)		(Give	kind of work do DO NOT use re	one during mo tired)	ost of worki	ng		Engine	•	
212	filed with Hygiene. other ther	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) one year	'	Stat	e Highv	vay Te	chnici	ian	Luthe	rville	, Maryl	and
b	il Hygie other	Be C	17. Father's Name (First, Middle, Last)					18. Mot	ther's Name	(First, Middle	, Maiden Sum	пате)		
lar		To E	Calvin J	. Skinner					Eve	elyn Co	rrine	Wright		
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type	e, Print)			ng Address (Str							
	and 2 salth n 27 l		Valerie J. Owens				Old Che							
ore	ges 1 ar t of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Re	moval from State	cem	netery, cre	osition (Name o matory or other	place)		ate	20c. Locatio	on - City or To	own, State	
Ē	nit. Pag artment ortant: b injury o		`4 □Donation 5 □Other (Specify)	movar nom orate	R.A.	. Ferr	is & Co.,	Inc.	04/0	7/04	West Ch	ester, I	Pennsylva	mia
Baltimore,	permit. Pages Department of Important: If if eny injury or c		21. Signature of Funeral Service Licenses		/	L.	2. Name and Ade A	ddress of Fac	on &	Son Fur	eral H	ome F	Р Д	
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P			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each tine	ne death.	Do not en	ter the mode of	dying, such a	as cardiac o	r respiratory a	rrest,		Approximate Interval Betwee Onset and De	en eath
	Physician	1	Immediate Cause (Final disease or condition	Lun	e (رمص	rater	0						
	/Medical Examiner		resulting in death)	Due to (or as a	con uer	nce of):	CA 44	112	-1					
腸		L.	Sequentially list conditions, b.	Due to for as a	6/100	x Tr ha	CI in	MIL	76- 1	nj vng.	A			
P	pei isit	nln n	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury	00010 (01 00 0						^/\	/ \			
, ,	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequer	nce of):				-/\/\				
,092	siciar buris	calE	1					CERTIFICAT	TION APPROV	ED BY MIDIC	MINERAMINER			
687	ficate p phy is the		0.						11/1/	CALED				
Вох	eath certificate be exattending physician for use as the buria	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of			75	\ V	BI	E Wen	23d.	Date of delive	эгу	
	death e atte d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at tir			⊒Ectopic pregn: ☐ Other <i>(specif</i>)	NIN	RPPROVED			Month	Day Ye	ar
0	that the de ed by the detached	hys	9 Unknown	9□ Unknown				CATI	OM					
o,	The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	by P	Part II. Other significant conditions cont	ributing to death but	not resulti	ing in the u	inderlying cause	gwen in Par	rt I.	23a. Did	tobacco use c		ne cause of dea	
Vital Records,	w require been sign	ed								1 🗆	Yes 2□No	3 Prob	ably 4 ⊠Un	known
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ita	icien: The certificate rector, pag	Be C	25. Was case referred to medical exampler?					26. Pla	ace of Death	(Check only	one)			
of V	Phyaicien: this certific ral director,	2	Yes 2□ No	ospital: 1 Inpatient		VOutpatie			Nursing Ho	me 5 Res	dence 6 🗆	Other (Specif	y)	
n c	ng P	O.	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time o		Injury at Work?	/ 1	28d. Describe	how injury oc	uerred 7	ruck	
sio	tendi leath lor: A	catl	2 Accident investigation 3 Suicide 6 Could not be	5-14-21	00419	lid		1 Yes 2		neno		,	10	
Division	i or Attending later death. Director: After in by the funer	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	y - At nom (Specify)	e, farm, st	reet, factory, off	/ A V	1	28f. Location (wn, State)	imber or Hura	I Route Numbe	ar. A ret
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physi	airay Ta the bast of	my knowle	₩ U	MUVV	1 T J	and place	N.J.	Canceles and	and 1	My Acom	Ke I
	Hos 24 ho Fun stely	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	er: On the basis of e	xaminatio	n and/or in	vestigation, in r	ny opinion, d	leath occurr	ed at the time,	date and place	ce, and due to	the cause(s)	
	ithin c the	Me	29b. Signature and title of certifier				29c. Lic	ense numbe	er .		29d. Date sig	ned (Month,	Day, Year)	
	⊢s⊢ŏ		>////				D	OCY-C	297		41.	100		
-			30. Na and address of person who con	npleted cause of dea	ath (Item 2	3a) (Type	Print)	المال	010		-1	1104		
	8		22 S. Ge	· —		3.	14mo	~ ^	10	2120	1			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signatur	re A	1		- /	-	+			
	Regist		APR 0 6 2004	ALL DESCRIPTION	2 All	- C - C - C - C - C - C - C - C - C - C	3 Charles							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Betty Delores Peed 5, April 5:56 A M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔏 F Yrs. 216-40-5238 Director 66 1937 Washington DC Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28e-f show The Medical Examiner must be notified at 1 ☐ Yes X☐ No Director Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8505 Timothy Road 20613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home or other treumatic event, land 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Lake Edward Ransom Rosie Bell Fogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Susan Brickman-Daughter 17109 Milltown Landing Road, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Ch. Cem. 4-8-04 Baden, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156 21. Signature of Funeral Service Licensee M00053 Mark M. Brohamin 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE RESPIRATORY **Physician** /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown tune cernicate has been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one. Other: 1 ☐ Yes 2 🛛 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D48158 04-05-2004 Jessems sterns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

- Esse

#500 DXON HILL MID 20745

SISOM OSIA 6192 OXON HILL RD

31. Date filed (Month, Par) 6 200 432. Registrar's Signature

		•	1 - For State Registrar	State of Mary	rland / Dep		nt of H	ealth an	d Mental Hy		2001.	130)6L
ľ	Physici /Medic		1. Decedent's Name (First, Middle, Las William Mar	vin Perd	ue				2. Date of D Month March	7, Day	2004 Year	3. Time of 5:55	
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	a or 28a-f	I Directo	10e. Street and Number 3682 Idlewild				ip Code	21632			izen of What Cou		
220	be filed within 72 hours after death with the Maryland nat Hygiene. all Hygiene. d other then "naturel", or itema 23a or 28a-f ehow event, the Medical Exeminar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give A Year or Dates:	r in U.S. 13			ispanic Origin n, Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Amer Black, White Specify: B1	, etc.	
Maryland 21213-0036	ad within 72 ho rgiene. er then "natu i, Ine Medical	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)		(Giv life.	edent's Usi e kind of w DO NOT ck D1	ork done d use retired	during most of) 		Tru	ind of Business/li	ndustry	
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ב ב	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Licen	m. Coal	le ?	22. Name a	ind Addres	ss of Facility F	ramptom	Fun rals	neral H	ome, MD 21	P.A. 632
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	To To Co T	2	29b. Signature and title of certifier 30. Name and address of person who	completed cause of death	h (Item 23a) (Tvn		DZ	7887			te signed (Month	n, vay, Year)	
	Sta Regist		David Smith 31. Date filed (Month, Day, Year)	M . D . 2	466 Pin	<u>+111</u>	Dε.	Suite	#5, Ea	ston	, MD 2	1601	

Registrar

Alatio Monuel Guerreio

			1 - For State Registrar	State of	Marylar		artment of H				0	001	10000
			Registrar 1. Decedent's Name (First, Middle, L.	ast)		Cel	uncate of	Deam		2. Date of De	Reg. No. <	004	3. Time of Death
	Physici		Acacio Manuel Gu		Pereir	a				Morth	2984	2 Year 4	0.22 PM
	/Medic Examir		4a. Facility Name (If not institution, ga			<u> </u>	4b. City, Town, o	r Location o		1110.00	VI V.	unty of Death	7,00
b	-Admi		Doctor's Communi	ty Hospi	tal		Lanham					nce Geo	orge's
	Funeral		5. Social Security Number 6.	Sex		last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h.	0.014	place (State or Foreign
	Director		220-06-94/8	1XM 2□F		58 Yrs.	Wioning Days	710013	14(1).	May 31	, 1945	Port	uga1
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					1	IOd. Inside City Limits
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	r 28a	rec	10e. Street and Number	GEOIGE 3	GI	Sember	10f. Zip Code				10g. Citizen	of What Cour	ntry?
	th with	Funeral Director	129 Rosewood Dri	ve			20770				USA		
	ems ems	ner	11. Marital Status	12. Was Dece Armed For	dent Ever in U		Was Decedent of H f Yes, specify Cubi	lispanic Ori	gin? (Spe	cify Yes or No-		Race - Americ Black, White,	
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<u>Na</u>	Ments Ments arked	To	Manuel Rodrigues	Pereira				Maria	a Dur	valina	Guerr	eiro	
ar	2 sho		19a. informant's Name/Relationship	(Турв, Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rurai	Route Numbe	r, City or To	wn, State, Zip	Code)
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JO.	ages nt of I t: If it		1 ☐ Burial 2 X Cremation 3 (State	cemetery, crer	natory`or other plac	· 1	March			on - City or To	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show eny injury or other treumetic event, the Medical Examinar must be multiled at once.		 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 		W •		1 Cremato	• '	200			n, Mar	•
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()	1/20		30. Name and address of person who	1 400 1	1 1		Print)	207	121				
1	/ U	10	8118 G-OODLUC, 31. Date filed (Month, Day, Year)	22 DA	gistrar's Signa	tura	7 - 7	~ /	<i></i>				
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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3	/Medical Examiner			give street and nun					4b. City, Tov		ation of Deal			11:30	PM
\neg		McCrea	ady Memo	orial Hosp	oital				Cri	isfie	ld		S	omerse	t
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	pu *	Usuel Residence of 10a. Stete	f Decedent 10b. County		10c. C	ity, Town or Lo	cation				_		1	0d. Inside City	v l imite
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ion	Attending Pindeath. Cotor: After the by the funeral iffcation:	27. Manner of Death 1. Naturat 2 Accident	5 Pending investiga	ition	Injury , Dey Year)	28b. Time of Injury	м	28c. Injury Worl 1 ☐ `	/et k? Yes 2□N		8d. Describe	how injury occur	red		
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	Hospi 4 hour Funer tely fill	29a. Certifier (Check only one)		Physician: To the backaminer: On the backers	sis of examina										
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		30. Name end eddre	ess of person w	no completed cause	of death (Ite	m 23a) (Type, F	rint)	18/7	Z _	Sara	ıd Bara	al, M.D.			
ľ	State Registrar	31. Dete filed (Mont	th, Day, Year) 2 6 200	4 52. Rd	gistrar's Signa	ature	bou	les .							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Julian Thomas Rawlett, Jr. March 28, 2004 11:59 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Prince_George's 5. Social Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Director 224-22-6686 April 1925 Virginia Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location ir then "naturel", or items 23a or 28a-f show If e Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland | Prince George's Brandywine 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10505 Cedarville Road Funeral 20613 United States 12. Was Decedent Ever in U.S. Amed Forces? 1 MYes 2 □ No 1943 – Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No ģ 3 X Widowed 4 ☐ Divorced 1946 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 Il Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Automobile other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental h ပ Julian T. Rawlett, Sr. Mary Ellen Inscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Louise Gordon-daughter 34090 Constitution Hwy., Locust Grove, VA 22508 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial Gdns! 04-02-2004 Fairfax, Virginia 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility M00053 Huntt Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Acute **Physician** Interction /Medical Examiner orondry Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown extension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 3∏ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or Avithin 24 hours after or To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JODRIE, M.D.

APR 0 1 2004

32. Pogistrar's Signature

29c. License number

D40324

7503 SURRATTS ROAD, CLINTON, MARYLAND

29d. Date signed (Month, Day, Year)

MARCH 29, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time 2337 April 10 **Physician** 2004 Myrtle Lee Roberts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F 87 217 32 7804 Director July 23 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23a or 28a-1 show the Medical Examinar must be notified at Maryland Calvert Prince Frederick 1 ☐ Yes 2 No Completed by Funeral Director 10f. Zip Code 20678 10e. Street and Number 10g. Citizen of What Country? Box 194 Dares Beach Road United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rant of Health and Mental Hygiene. In: It item 27 is marked other then "naturel; or Ite ury or other traumatic event, the Madical Examinatiny or other traumatic event, the Madical Examinating. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Elliott Be Perry Elliott ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Clay Harmond Road Prince Frederick, MD 20678 William Ronald Roberts—son 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wesley Cemetery or other place) April 15 2004 Prince Frederick, Maryland permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home DI. 4405 Broomes Is. rd. Port Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 4□Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? JEYes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury

Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, death. within 24 hours after deat To the Funeret Director: ģ To the

1 Matural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D059409 04.12.04 MM ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl

31. Date filed (Month, Day, Year) State

VUSU

SHAH 32. Registr#s Signature

MB

2004▶

13

CALV MED OFFICE BLDG SUITE 303

P. Frederic

Registrar

Medicai

ASSOC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day **Physician** 23, 2004 Richard Kelly Rowe March 1:15 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner 8701 Antietam Drive Walkersville Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 152 M 2□ F 73 Director 381-26-8157 April 25, 1930 Michigan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, it a Medical Examinar must be inclified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21793 8701 Antietam Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1947 – 1XXYes 2 □ No If Yes, Give 1948 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates:1951-53 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Supply Service Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Goldie Lumley Harold S. Rowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8701 Antietam Drive, Walkersville, MD 21793 Karen R. Rowe / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Mar. 24 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 2004 21. Signature of Funera 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21/01 the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complication stock, or heart failure. List only one cau Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner by Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Medical Certification: To Be Completed 1 ☐ Yes 2 ☐ No eral Director: After this certification filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No daath. 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 29a. Certifier 1 🗇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. To the Hoss within 24 ho. To the Fune. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signatur

Registrar

State

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

			1 - For State Registrar		State o	f Maryla		artmen ertificat				lental I	Hygie Reg.		04	131	068
			Decedent's Name (First)	Middle, La	ast)					_		2. Date of	f Death		Vari	3. Time of	f Death
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	Examir		4a. Fecility Name (If not in:	titution, gi	ve street and nur	nber)		4b. City,	Town, or	Location	of Death			4c. County		10.12	
			3417 Campus							ville				Free	deric	k	
	Funeral		5. Social Security Number		Sex 1⊠M 2□F	7. Age (In yrs) If Under Months	1 Year Days	If Under Hours	Min.		, Day, Ye	ear)	Cour	lace (State o	-
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	land ow			County		10c. C	ity, Town or L	ocation							1	0d. Inside C	ity Limits
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Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is merked other than "natural", or Items 23s or 28s-1 show or other traumatic event, The Medical Examinar must be notified at	by	1 ☐ Never Married 25 3 ☐ Widowed 4 ☐ Dr		Armed Fo 1 X Yes If Yes, Giv Year or D	2 No Dese	ert	1 ☐ Yes			i, Puerto i	Hican, etc.	,	Specif	_{y:} White,		
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Ba	permit. Pages Department of Important: If it any injury or o		21. Significate di bulletats		6			2. Name and 621 Op			Sta					s, P.A land 2	
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ā	ifficat or, pi	e C	25. Was case referred to m	edical						26 Place	of Dooth	1 Ye		No 1	Yes	2 No	
>	Physician: r this certifica ral director,	To B	examiner? 1(XYes 2 ☐ No		Hospital:	npatient 2	ER/Outpatie	- nt 3□ DO	Othe			(Check on		e V ioth	or /Connib	at sce	200
0	g Phy er thi		27. Manner of Death		28a. Date o	f Injury	28b. Time o		c. Injury	at	2	8d. Descril	be how in	njury occurr	ed ,		erie
Division of Vital Records,	Attending r death. sctor: After by the fune	atio		Pending nvestigatio		Day Year	10:28	A M	Work 1)XY	? ′es 2	40 S	subjec	list +	from	light	pole	
Vis	Atte	iii c	3 Suicide 6 □	Could not b	280. Place	of Injury - At h	ome, farm, st	reet, factory,	office	- The Part of the	2	8f. Locatio	n (Street Town, St	and Numb	er or Rural	Route Numb	ber,
ō	tal or	Certification:	T [] Hormore		7	ig, etc. (Speci		id			3	471 C	ampi	5Dr.	Ijams	ville, N	D
	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Pl	nysician: To the miner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred a vestigation,	it the time	e, date and inion, deat	d place, a h occurre	nd due to t	he cause ne, date a	e(s) and ma and place, a	nner as stand due to	ited. the cause(s)	
	To th withir To th sompl	Me	29b. Signature and title of o	ertifier				29c.	License	number			29d. [Date signed	(Month, L	ay, Year)	
)			Jaska	21	Treen	Sera	MA			O.C.	M.E.		Ma	rch 1	9, 20	04	
	20		30. Name and address of p	1	completed cause	of death (the	n 23a) (Type,	Print)	-				1				
_	N		Tasha Z C	ireer		1.D.	111	Penn S	Stree	et. R	altin	nore.	Mar	vland	2120	1	
	Sta		31. Date filed (Month, Day,	4176	- 4	gistrar's Sign	ature							,			
156	Registr		MAR	5.5	CUU4	house	10% A	TOP	9								
DH	MH 17 Rev 1/20	001			7		1										

ORIGINAL

		State of State of Registrar	Maryland / Dep Ce	ertificate of E			ne No. 2004	13069
Physici /Medio		1. Decedent's Name (First, Middle, Last) James Broschar				2. Date of Death Month March 15	Day Year 5, 2004	3. Time of Death 2:50A M
Examin Funeral	er	1 X 1M 2□ E	Age (In yrs. last birthday	4b. City, Town, or I Damascu J If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	Mont gome	
Director		217-28-1751 Usual Residence of Decedent 10a. State 10b. County	74 Yrs.	ocation		May 13,		yland 10d. Inside City Limits
of a should be filed within 72 hours after death with the Maryland of 2 should be filed within 72 hours after death with the Maryland for and Mental Hyglene. 77 is marked other than "natural", or Items 28a or 28a-f show traumatic event, the Mardical Examiner mant be notified at	To Be Completed by Funeral Director	Maryland Montgomery 10e. Street and Number 25900 Woodfield Road 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 New Year or Date 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) Earl B. Richards	as? XINo ass: 16a. Decc (Given) iffe.	10f. Zip Code 20872 Was Decedent of His If Yes, specify Cuban 1 □ Yes 2√√2 No edent's Usual Occupate e kind of work done du DO NOT use retired) Salesman	, Mexican, Puerto F Specify: ion irring most of workin 18. Mother's Name Mildred	cify Yes or No- lican, etc.) g (First, Middle, Maid Hawkins	. Kind of Business/li Tires den Sumame)	ican Indian, , etc. i_te ndustry
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type, Print) Mary Waters Richards — Wi: 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Onation 5 □ Other (Specify) 21. Signature of Fundral Serve Licensee	fe 2590 20b. Place of Dispresentery, cre Damascus	ing Address (Street ar. O Woodfie osition (Name of smatory or other place) S Meth. Cen (2 Name and Address O 6 (0 1 Prides)	ld Road, Da netery 3/ of Facility Lesworth	Damascus, 20c 18/04 Da P.A., Fur	Maryland Location - City or T mascus, M neral Home	1 20872 own, State faryland
ate be nysicia he bur	ical Examiner	shock, or hear failure. List only one cause on each search of the failure. List only one cause on each search of the failure o	as a consequence of): as a consequence of): as a consequence of):					Approximate Interval Between Onset and Death 20 years
deati certific e attencing p	by Physician/Med		n 2 ☐ Fetal death 3 [t at time of death 5 [□Ectopic pregnancy □ Other (specify)	3.5	-	23d. Date of deliv Month	ery Day Year
law requires that the as been signed by the 2 should be detached.		Part II. Other significant conditions contributing to death	h but not resulting in the t	underlying cause given	in Part I.	11 -	o use contribute to t	he cause of death?
The ate h	e Completed	25. Was case referred to medical			20. 50	24a. Was an autopsy performed 1 Yes	prior to co	ppsy findings available impletion of cause of
ng Phy fter this ineral d	ertification; To B	examiner? 1	njury 28b. Time o Day Year) Injury	of 28c. Injury a Work?	t 28		6 Other (Special	(y)
ra le	Medical Certific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of building, 29a. Certifier (Check only one) 1 Certifying Physician: To the basis and manner and manner	s of examination and/or in	h occurred at the time.	date and place, an	City or Town, Sta	(s) and manner as s	tated
To the within 7 To the comple	Mec	29b. Signature and title of centifier	Sidiled.	29c. License r			Date signed (Month,	
12		30. Name and address of person who completed cause of	=	Print)	24571	Ma	rch 15, 2	004
Stat Registra			strar's Signature	Sonelle 3	Ca (d see	via		

	1 For State Registrar 1. Decedent's Name (First, Middle	State of Marylan		artment rtificate			d Mental Hy	Reg. No.	2001	3. Time of Death
Physician /Medical Examiner	James Arve 4a. Facility Name (If not institution,	Robinson give street and number)		4b. City, To	own, or Loc	cation of De	Month March	21 4c.	2004 County of Death	9:40 P
Funeral Director	Caroline Nursin, 5. Social Security Number 214-03-3129 Usual Residence of Decedent	3 Home 3. Sex 7. Age (In yrs. 1) 1	last birthday) Yrs.	Dent If Under 1 Months	Year If	Under 24 Hours M	lin. (Month, D	rth ay, Year)	aroline 9. Birti 008 Mary	nplace (State or Fore unitry) "Land
rat, or items 23a or 28a-f show Examinat must be notified at 1 by Funeral Director	10a. State 10b. County Maryland Queen 10e. Street and Number 29527 Queen Annu 11. Marital Status 1 XNever Married 2 ☐ Marrie	Anne Qu Hwy 12. Was Decedent Ever in U Armed Forces?		10f. Zip C	57 nt of Hispa y Cuban, N		(Specify Yes or N erto Rican, etc.)		Zen of What Co U.S.A. 14. Race - Ame Black, White Specify: Wh	ncan Indian, o, etc.
ygiene. ner then *natural', it, it is Medical Exit Completed by	15. Decedent' (Specify only highes: Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual of work DO NOT use	done durir retired)	ng most of i		fo	nd of Business/l	
even Be	17. Father's Name (First, Middle, Lacy Arvel Robi: 19a. Informant's Name/Relationsh	ison	19b. Maili	ng Address (S		Zada	Name (First, Middle Alma Hur Rural Route Numb	ter		ip Code)
Department of Health and Mer important: If Item 27 is marks any injury or other traumatic once.	Holton Rhodes J. 20a. Method of Disposition 1 Maurial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service L.	3 □Removal from State Greatfy) 20b. F	Place of Disposementary, crei	2. Name and	of erplace) etery Address of	Facility	s MD 21 24/2004 nbein Fur	Gree		Maryland
ysician Medical caminer	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	uence of):	Box 1	60 (Green	sboro. Ma	ry1a rrest,		
hysician and the burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C								
d by the attending phy letached for use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic preg				2	23d. Date of delik Month	very Day Year
be o	Part II, Other significant condition	s contributing to death but not res	ulting in the u	inderlying cau	se given in	Part I.	23e. Did		V.	the cause of death
page 2	25. Was case referred to medical				26	Place of F	24a. Was auto perfe 1 Yes	psy ormed? 2DNo		opsy findings avails ompletion of cause 2 No
tor: After this the funeral d the funeral d cation: Te	examiner? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide	of be 200 Blood of laine. At he	28b. Time o Injury	f 280	Other: 2 c. Injury at Work? 1 Yes		g Home 5 ☐ Resi 28d. Describe	dence 6 how injury	occurred d Number or Rui	ral Route Number,
within 24 hours after of To the Funeral Direct completely filled in by Medical Certification of the completely filled in	29a. Certifier (Check only one) 29b. Signature and title of certifier	Physician: To the best of my kno xaminer: On the basis of examina and manner stated.	wledge, deat tion and/or in	vestigation, in	i my opinio	n, death oo mber	ccurred at the time,	date and	place, and due	Day, Year)
¥ 1, 20	30. Name and address of person v	ho completed cause of death (Item	40 1 23a) (Type,	De	04	753	Li		3/22/	04
State	Wafik Zaki MD 31. Date filed (Month, Day, Year)	920 Market St		enton,	MD	21629				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:01 PM Rohrman March 2004 30, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 8, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2\ F Yrs 180-16-9229 1922 Philadelphia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at MD Worcester Berlin 1 XYes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21 Fair Haven Court 21811 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ring most of working Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Wine Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry E. Rohrman Emily A. Keller 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau Henry Rohrman - Brother 21 Fair Haven Ct., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State Hillside Cemetery4/3/2004 Roslyn, PA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility choenberg Memorial Chapel 19 Philadelphia Pike, Wilm. DE 19809 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alchimurs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Disease or a righty that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760, Physician/Medical use as the Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Δ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification; To Be Completed by 3 ☐ Probably 4 🖫 Onknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Yes 2 V No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

3

31. Date filed (Month, Day, Year)

2004

D.0.19

Hey! Hway

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HUU53717

DRIVE

31/04

		1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of	Health a Death	and Mental Hy	Reg. No. 2 U	04 13072
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Muriel Maier	Selph				2. Date of D March	3 I ^{Day} 2 0 0 2	3. Time of Death 9:30p M
Examin		4a. Facility Name (If not institution, give s Genisis Elderca			4b. City, Town, LaP1a		f Death	4c. County o	f Death Les
Funeral Director		., = 0 0 1,50	7. Ago M 2 ∏ F	e (In yrs. last birthda) 81 Yrs.	Months Days	If Under 2 Hours	8. Date of Bi	7 ^{ar)} 1923	9. Birthplace (State Decreign B Washington
anyland show	70	Usual Residence of Decedent 10a. State 10b. County MD Char1	es	10c. City, Town or I	ocation Victoria	2			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ith the Marylar or 28e-f show	recto	10e. Street and Number		110.	10f. Zip Code	<u>а</u>		10g. Citizen of Wh	
th with 23a or	al Di	12570 Wicomico	Knolls	Farm	20	661		US	SA
ine; intally latter Z. I.Z. I.Z. COOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Microport	2. Was Decedent I Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of If Yes, specify Cut		gin? (Specify Yes or N., Puerto Rican, etc.)		- American Indian, , White, etc. White
thin 72 hours on "nature" I Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	(Giv life.	edent's Usual Occu e kind of work done DO NOT use retire	during most ed)	of working	16b. Kind of Bus	iness/Industry
iled wi		17. Father's Name (First, Middle, Last)	4	P	ublishe		r's Name (First, Middle	News	paper
ally allow A. I.A. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event.	To Be	George S. Maier					a M. Chri		,
and 2 sho ealth and 1 n 27 is me er trauma		19a Informant's Name/Relationship (Type Victoria E. Sel]	oe, Print) ph/Daugh				r or Rural Route Numb Pl. La		
Pages 1 and nent of Health ont: If item 27 ary or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State	20b. Place of Disp cemetery, cri	osition (Name of ematory or other pla	ace)	Date	20c. Location - C	city or Town, State
Description of permit. Pages 1 a Department of Hee Importent: If item any injury or othe once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	• MO	Brinsfie 00945			LS FUNER		tte Hall,MD
205 29		23a. Part 1. Enter the disease, or complice	chul	the death. Do not e	P.O. BO	X 567	7 LA PLAT	A.MD. 2	0646 Approximate
Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ADV	a consequence of):	7		SLIENO,		Interval Between Onset and Deeth
ate be executed ysicien and he burial-transit	icai Examiner	fi any, leading to immediate cause. Enter Underfung Cause (Disease or injury that initiated events resulting in death) Last	Da to (or as	a consequence of):	LA.				* month
Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	су		23d. Date Month	
w requires that sheen signed be should be detailed.	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the	underlying cause gi	ven in Part I.			oute to the cause of death?
ilcian: The law re certificate has bee	Completed						24a. Was auto perfo 1 \subseteq Yes	psy pric	ere autopsy findings available or to completion of cause of ath? Yes 2 □ No
ding Physician: h. After this certific funeral director.	on; To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Autural 5 Pending	ospital: 1 Inpatie 28a. Date of Injur (Month, Day	nt 2 ER/Outpatie ry 28b. Time / Year) Injury	ent 3 DOA	her: 4CX\ur	of Death Check on sing Home 5 Resi		
To the Hospitel or Attending within 24 hours alter death of the Funerel Director: Alter completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, s c. (Specify)		Yes 2 N	28f. Location ((Street and Number wn, State)	or Rural Route Number,
Hospite 24 hours Funerel stely filler	Medical C	29a. Certifier (Check only one) Certifying Phys	ician: To the best of er: On the basis of and manner sta	examination and/or i	th occurred at the tinvestigation, in my	ime, date and opinion, death	I place, and due to the n occurred at the time,	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	Jol)	how	29c. Licen.	se number	29	29d. Date signed (Month, Day, Year)
NP 10		30. Name and address of person who con	1-1.12 r	7-T-1-16	m M	014	JAMO NO	7 N. M	(20603
Sta Registr		31. Date filed (Month, Day, Year) 0 2	2004 Regis	ar's Signature	Species		· · · · · · · · · · · · · · · · · · ·		

			1 = For State Registrar	State of Maryland			f Health a of Death			21	004	13071
	Physici	an	Decedent's Name (First, Middle, Last	-				2.	Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	reige	2		n, or Location o		pril	4c. County	004 of Dooth	4:00 AM
60	Examir	er	Johns Hopkins Hos				more Ci			None	OI DOGUI	
	Funeral Director		5. Social Security Number 6. S		st birthday) Yrs.	if Under 1 You Months Da	ear If Under	24 Hrs. 8. (Date of Birth Month, Day, V 25,	Year)	9. Birthp Coun Flor:	
	pu »		Usual Residence of Decedent	10-0	Ŧ			1100	,v_25j	1501		
	anyla ahov	JQ.	10a. State 10b. County Maryland Prince G		Town or Lo andyw:						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the A	rect	10e. Street and Number	eorge s Di	andyw.	10f. Zip Cod	le		10	g. Citizen of V	What Coun	
	h with	al Di	15555 Park Avenue	:			0613			USA		-,,
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow appring yor other traumatic event, I'm Medical Eratri net must be usuffied at ODGe.	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 【\textbf{Y}No If Yes, Give Year or Dates:		Was Decedent f Yes, specify (of Hispanic Original	gin? (Specify i, Puerto Rica	Yes or No- n, etc.)		e - Americ k, White, Wh	etc.
21215-0036	in 72 hou	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	lent's Usual Ockind of work do	ne durina most	t of working	1	6b. Kind of Bu	ısiness/Inc	lustry
212	d with giene. rr than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Disal		00,			Disa	bled	
	be file tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (Fir	st, Middle, M.	aiden Sumam		
Maryland	f Meni marke	2	Brian Simonet							Simone		
ā	th and 1th and 27 Ian traun		19a. Informant's Name/Relationship (7) Kathryn J. Simone				eet and Numbe. Ave. Br					Code)
ē,	s 1 ar if Hea item 2		20a. Method of Disposition	20b. Pla	ice of Dispo	sition (Name of natory or other		Date		Dc. Location -		wn, State
altimore,	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-		ematory	4-3-0	4 A1	exandr	ia, V	/A
Balt	permit. Departr Importa any inj		21. Signatur of Funcial Service Licen	bew MOO	173 44	433 Whi	dress of Facility	Eber La. W	hite P	uneral	Serv D 206	rices 595
l,	Physician		23a. Part 1. Enter the disease, or comp spock, or heart failure. List only Immediate Cause (Final	one cause on each line.	-							Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a conseque	1511 ence of):	ary C	irrhosi	isano	datre	1519		22 years
	Examiner		Sequentially list conditions,		iver	Transp	plant 1	Rejec	tion			4 years
	led sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):	,		0				1 1
Ć,	execu n and ial-tra	Exan	that initiated events resulting in death) Last	c. Hemorrhae Due to (or as a conseque								1 day
8760,	ficate be executed physician and is the burial-transit	dicai	(d								
9	ertifica ling ph e as th	Med	IF FEMALE:									
O. Box	the death certifi y the attending iched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	leath 3	Ectopic pregna Other (specify)				23d. Date Mor	e of deliver oth I	y Day Year
ecords, P	law requires that the de as been signed by the a 2 should be detached f	ρχ	Part II. Other significant conditions or	ontributing to death but not result	ing in the un	iderlying cause	given in Part I.		23e. Did toba 1 ☐ Yes	h /		a cause of death?
Ö	s been si should	iete							24a. Was an	24b. V	Vere auton	sy findings available
Υ	0 - 0	Completed							autopsy	d? d	rior to comeath?	ipletion of cause of
VItal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		-				ack only one)			
0	Phys this ral dii	일:	1 ☐ Yes 2 No 27. Manner of Death		R/Outpatient	30 DOX		-		ce 6 ∏Othe		
	ding Ph th. : After th s funeral	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		njuryat Vork? □Yes 2□N		Describe now	injury occurre	ea .	
DIVISION	a Hospital or Attend 24 hours after death Funeral Director: A etely filled in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	et, factory, office	C8	28f. L	ocation (Stre	et and Numbe State)	or or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exam	rsician: To the best of my knowl iner: On the basis of examination and manner stated.	edge, death en and/or inv	occurred at the estigation, in m	time, date and y opinion, death	place, and d h occurred at	ue to the cau the time, date	se(s) and mar and place, a	nner as sta	ted. the cause(s)
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0.1	P 3		30. Name and address of person who o	ompleted cause of death (Item 2		Print)	fe Stra	1 2	2011			- c/a 0 - 1
0	Sta	e	31. Date filed (Month, Pay Keap 5	32. Registrar's Signatu	Nort	n wol	te stra	eet 13	x47m0	re M	D 21	201-4106
io.	Registra		Ark U D	LUUA NOCKE.	B. A	South .						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 31, 1935 P M 2004 HENRY EUGENE SMITH /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES HOSPITAL CENTER PRINCE GEORGES CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** OCTOBER 29, 1979 1**X** M 2□ F MARYLAND 578-02-3403 24 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1 TyYes 2 □ No Director MARYLAND PRINCE GEORGES CAPITOL HEIGHTS 10e. Street and Number 10g. Citizen of What Country? UNITED STATES 20743 items 23a 6888 WALKER MILL ROAD, APT. 204 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 □ Yes 2 No Specify Specify: BLACK If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NONE DISABLED 9TH GRADE other t of Health and Mental Hv. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MARIAN ELIZABETH WILLETT HENRY CANNON SMITH 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 iit. Peges 1 and 2 st artment of Health and ortant: If Item 27 is 1 6888 WALKER MILL ROAD, APT. 204, CAPITOL HEIGHTS, MD MARIAN E. WILLETT / MOTHER 20a. Method of Disposition

AD Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Peg Department Important: I any injury o RESURRECTION CEMEINA APRIL 8, 2004 CLINION, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Fula and Semple into the 22. Name and Address of Facility THORNION FINERAL HOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Mulhple **Physician** gunshot wounds resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dub to (or as a consequence of). Examiner and Due to (or as a consequence of): the attending physician a ned for use as the buriat-Box 68760. certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \(\subseteq \) No autopsy performed? certificate 1 Nos 2 No 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 💢 DOA 1 X Yes 2 ☐ No this 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 7.00 PM After 1 Natural 5 Pending subject was shot 289. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 XNo death. investigation 2 ☐ Accident Director: 6 Could not be determined 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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28f. Cav 3 ☐ Suicide in by t 4 M Homicide hours after ö within 24 hours a To the Funeral I 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME Jacka 1 Theenters MA APRIL 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP lasha Z Greenberg M.D 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) APR 0 32. Registrar's Signature State 7 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Ethel G 12:00 PM Simmons April 7 4b. City, Town, or Location of Death 2004 4a Facility Name (If not institution, give street and number) 4c. County of Death Bradford Oaks Nursing Center Clinton If Under 24 Hrs. Prince Georges 5. Social Security Number 8. Date of Birth April 24,1910 Maryland 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M XXF Months Days Hours Min. 93 578-20-6640 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1X Yes 2 □ No Upper Marlboro Maryland | Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 11411 Duley Station Road USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3K Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Margaret Brown E Brown Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10913 Phillips Dr. Upper Marlboro, Maryland 20772 Thomas Gray/ Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩₩Burial 2 Cremation 3 Removal from State Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/14/04 Clinton Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1323 Adams Funeral Home P.A. Aquasco, Maryland Cussa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia 3 days Due to (or as a consequence of) Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 20006 3 Probably 4 Unknown Seizure Disorder Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes **2**□{No 1 ☐ Yes 2XXVo 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 41XNursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

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should be filed within 72 hours after ad Mentel Hygiene. marked other than "natural", or ite

permit. Pages 1 and 2 should be file Deportment of Health end Mentel Hy important: If item 27 is marked othen yoly no other traumatic event

Baltimore. Maryland 21215-0036

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toepital or Attending Physician: The law requires that the death certificata be executed thours after death.

Uneral Director: After this cartificate has been signed by the attending physicien end sly fillad in by the tuneral director, pege 2 should be dateched for use es the buriel-transit attending physicien I for use es the bune Medical Certification:

of Vital Records, P.O. Box 68760, Division

To the H	within 24	To the Fi	complete
P		7	

State Registrar 29b. Signature and little of run au

5 ☐ Pending investigation

6 Could not be determined

1 ☐ Yes 2 ☐ No

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D 005Z 999

who completed cause of death (Item 23a) (Type, Print)

SURRATTS ROAD 7501 205

CLINTON MD 20735 ALI RAHIMIAW MD

31. Date filed (Month, Day, Year)

1 Natural 2 Accident

3 Suicide

29a Certifier

4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 L 13076 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:20p M JAMES A. SAVOY 04 09 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert CONC If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex. 1 AM 2 F 7. Age (In yrs. last birthday) **Funeral** Mar.6,1924 219-12-3263 80 Director Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic event, the Modical Examiner must be notified at once. 1 ☐ Yes 2 💟 No Maryland Calvert Lusby Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12480 Rousby Hall Road 20657 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No 1943 — Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Issac Savoy Maggie Weems 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Savoy/Wife 12480 Rousby Hall Rd. Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Eastern UMC Cem. 4/16/04 Lusby, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD2067 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Wrine /Medical resulting in death) Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 25 Hospitel or Attending Physicien: '24 hours after death.' Funerel Director: After this certifica stelly filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 2 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Many r of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hc To the Fun completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Physica. 30. Name and address of person who completed cause of death (Fen 23a) (Type, Print) Anwar T. Munshi, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Oay, Year) 32. Registras Signature State APR 13 2004 Registrar

			ror	epartment of Health and M	ental Hygie	ne	10070
			negistrar	Certificate of Death		No. 2004	
	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Lance Carl Svanberg		2. Date of Death Month April	Bay 2004 ear	3. Time of Death 9:30a
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	J.50a
	LXummi		3231 Ina Chase	Chesapeake Beach		Calvert	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	Months Davs Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	olace (State or Foreign ntry)
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	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits
	Mary 1 sh	to	Maryland Calvert Chesap	eake Beach			1 ☐ Yes 2 ☐ No
	n the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
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	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
3	s 1 and 2 should be filed within 72 hours after death with the Maryland It health and Mental Hygiene. It marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	1 XNever Married 2 Married 1 Yes 2 No 1f Yes, Give A 3 Widowed 4 Divorced Year of Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: whi	te
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			. 4 □ Donation . S □ Other (Specify) Metrop 21. Signature of Funeral Service Licensee	olitan Crematory 4-8 22. Name and Address of Facility	-2004 AL	exandria,	VA
0	permit. Departr Importa any inje		Dina Mellach	Rausch Funeral Home	, P.A., O	wings, MD	20736
			23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart airure. List only one cause on each line.				Approximate Interval Between
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200	anding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	
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ń	The law requires that the death certificate are thas been signed by the attending phys page 2 should be detached for use as the		Part II. Other significent conditions contributing to death but not resulting in	OPD	1 ☐ Yes	/	bably 4 □Unknown
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Mec	and the standard of the standa	29c. License number	29d.	Date signed (Month,	Day, Year)
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	_		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) GYAN - (- SU	RANA	
	5		30. Name and address of person who completed cause of death (Item 23a) 5551 - Deale Church ton	Rd. Deale	mp	2075)
	Sta		31. Date filed (Month, Day, Year) APR 0 5 2004	Acoust &			
	Regist	rar	MEN UU ZUU4 WAREN JO				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 11:10P [™] March 12, 2004 Betty H. Sweeney /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 🖔 F Director 256-56-6760 67 27, 1937 Georgia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or Itams 23s or 28s-f show the Madical Examiner must be notified at Gaithersburg 1 ☐ Yes 2 No Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 24211 Laytonsville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) Telephone Operator 12th Telephone 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fill Department of Health and Mental H Important; if item 27 is marked oth eny plury or other traumatic even pose. G. DeLoach ဂ္ John Verbie Todd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20882 19a. Informant's Name/Relationship (Type, Print) Charles M. Sweeney - Husband 24211 Laytonsville Road, Gaithersburg, Maryland 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a, Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Denation 5 ☐ Other (Specify) Pine Grove Cemetery 3/17/2004 Mount Airy, Maryland 21. Signature of Fuheral Service Licensee 22 Name and Address of Facility Olin L. Molesworth P.A., Funeral Home torest Julians 26401 Ridge Road, Damascus, Maryland 20872-011 Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PAFUMDNIA **Physician** WEF /Medical Due to (or as a consequence ot): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initieted events resulting in death) Last Due to (or as a consequence ot) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 37 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 Yes 2 No 2 No neral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case reterred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Naturat 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier MARCH 13 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) HANNON NNISM MA 2901 2NO ROSD: DINE 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State MAR 6 Registrar

			T Stete Registrar	tate of M			of Health of Death	and Mental Hyg	giene 2004	13080
	Physici		1. Decedent's Name (First, Middle, Last)		51	toneb	erger	2. Date of Dea Month March	th Day Year	3. Time of Death 3 200 PM M
	/Medi Examir		4a. Facility Name (If not institution, give stre Garrett County Memo			4b. City, T	own, or Location		4c. County of Oea	th
	Funeral Director		5. Social Security Number 6. Sex 1 M M Usual Residence of Decedent	2□ F 7. Ag	52 Yr	Months	Year If Under Days Hours	8. Date of Birth Min. (Month, Day May 28	9. Bir Co , 1951 Vii	thplace (State or Foreign ountry) rginia
	e Maryland 8e-f show fills d at	ctor	10a. State 10b. County MD Garrett		10c. City, Town o	akland				10d. Inside City Limits 1 Yes 2 No
	with the	Dire	10e. Street and Number 706 East Alder Stree	. 4-		10f. Zip (1	0g. Citizen of What Co	ountry?
900	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural; or Items 23s or 28e-f show other treumetic event, the Medical Exerptree must be notified at	d by Funeral Director		Was Decedent Armed Forces? 1 ∑Yes 2 ☐	Everin U.S. No Viet Nam		21550 Int of Hispanic Or y Cuban, Mexica	igin? (Specify Yes or No- n, Puerto Rican, etc.)	USA 14. Race - Ame Black, White Specify:	
21215-0036	within 72 h ene. than "natu ne Medical	Completed		on ompleted) College (1-4or :	(6		done during mos retired)	st of working	16b. Kind of Business	•
Maryland 2	12 should be filed within in and Mental Hygiene. 7 is marked other than "Ireumatic event, the Med	To Be Co	12 17. Father's Name (First, Middle, Last) I Saac Tazewell	Sto	oneberger	Labore	18. Moth	er's Name <i>(First, Middle, I</i> ze1 Fran		cas
lary	2 shoul and Me Is mark	F	19a. Informant's Name/Relationship (Type,	Print)	19b. M	-	Street and Numb	er or Rural Route Number		
	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre <u>once</u> .		Harold L. Stoneberge 20a. Method of Disposition 1 Burial 2XCremation 3 Rem		20b. Place of Di cemetery,	isposition (Name crematory or oth	er place)	Date	20c. Location - City or	
Baltimore,	permit. Pa Departmer Importent any injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Done	Omega		Address of Facili		uneral Hom	
	Physician /Medical	(ii	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ons that caused ause on each li	d the death. Do not ne.					Approximate Interval Between Onset and Death
8760,	rate be executed xx any sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cle sac or knury that initiated events resulting in death) Last d		a consequence of):					
O. Box 6	the death certific by the attending pached for use as	Physician/Med	in the past 12 months?	If yes, outcome 1□Live birth 4□Pregnant at 9□Unkn <i>o</i> wn	2 Fetal death	3 □Ectopic prec 5 □ Other (spec			23d. Date of del Month	ivery Day Year
rds, P.	w requires that s been signed k should be det	þ	Part II. Other significant conditions contrib	uting to death b	ut not resulting in th	e underlying cau	ise given in Part I ≀`U ~	. 23e. Did tob	eacco use contribute to	
of Vital Records,	The law re cate has been page 2 sho	Completed	gastwessphase	ial ra	eflux	dise	us e	24a. Was ar autops perforn 1 \sum Yes 2	v prior to d	topsy findings available completion of cause of 2 No
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ■ No Hosp	ital:			Othor	of Death (Check only one		
on of	nding Phys th. : After this s funeral di	tion: To		1 ☐ Inpatie 8a. Date of Inju (Month, Da	ry 28b. Tim	e of 280	4 □ Nu 3. Injury at Work? 1 □ Yes 2 □	rsing Home 5 Reside 28d. Describe ho		city)
Division	el or Attendi s after death. Il Diractor: A od in by the fu	Certification;	a Deviside 6 D Could not be	8e. Place of Inj building, et	ury - At home, farm, c. (Specify)	, street, factory, o	office	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospitel or Attending Physician: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medicel Exeminer:	on: To the best On the basis of and manner sta	examination and/o	eath occurred at r investigation, ir	the time, date an my opinion, dea	d place, and due to the ca th occurred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
l	4	Σ	29b. Signature and title of certifier	Term	w M	29c. [icense number 002	1-1-	Nd. Date signed (Month	1. Day, Year) 2 004
	+1 VA		walter K. Nav	manr	eath (Item 23a) (Ty	pe, Print) POBOY	247.	Accident	-mD2	1520
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 1 2004	32. Registra	ar's Signature	The many				

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year 2004 Sherri Annette Sisler MARCH 0010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. ALLEGANY Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 13,1970 **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 K F Virginia Director 233-19-8647 Usual Residence of Decedent 34 West 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-1 show notified at 1 Yes 2 No Directo Friendsville Maryland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a 23a or : 7324 Cranesville Road 21531 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Exeminer in Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ŏ þ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Worker High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental is ant: If item 27 is marked o Leo Bernard Britner Sally White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Darrell H. Sisler/Husband 7324 Cranesville Road, Friendsville, MD 21531 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State ′5/04 4 □Donation 5 □ Other (Specify) Blooming Rose Cemetery Friendsville, MD permit. 21. Signature of Funeral Service License 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275; Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final) disease or condition resulting in death) **Physician** ANOXIC ENCEPHALOPATHY WEEKS /Medical Due to (or as a consequence of) **Examiner** b FLASH PULMONARY EDEMA Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last 4 WEEKS Due to (or as a consequence of): Examine certificate be executed physician and the burial-transit c. CARDIOMYOPATHY 2 MONTHS Due to (or as a consequence of): Box 68760, Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 XYes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 €No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Division of Vital 1 Yes 2 No 1 🗆 Yes funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Mapher of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 Yes 2 No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Kay MARCH 3/12004 D19318 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 517 OLDTOWN ROAD CUMBERLAND, MARYLAND DR. NAGARATNAM RANJITHAN 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 8 200

State of Maryland / Department of Health and Mental Hygiene 13082 Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey Year **Physician** SSEL marga 04 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND GARRETT 8. Date of Birth Month, Day, Year, AUG 31, 19 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F Yrs. 235-38-9866 80 WV Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2 📉 No Funeral Director MD GARRETT OAKLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 644 SILVER KNOB ROAD 21550 USA filed within 72 hours aftar death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) or Herns Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2)X No Specify Specify: WHITE 2 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) and Mantal Hyglana. Elementery/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER CEMENT COMPANY 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pagas 1 and 2 should be file Department of Health and Mantal Hy Important: If Item 27 is marked oth any linjury or other traumatic even Roca. Be THOMAS SIMMONS LENA BENNETT 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHARLINE SIMMONS - WIFE 644 SILVER KNOB ROAD OAKLAND, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State ACCIDENT CEMETERY 3/8/04 HORSE SHOE RUN, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature Fulleral Service Licensee P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ata has bean signed by tha attanding physician and paga 2 should be datachad for usa as the burial-transit or Attending Physician: The law raquires that the death carificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Lest 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 HYas 2 _ No 1 ☐ Yes 2 ☐ No within 24 hours aftar daath.

To the Funers! Director: Aftar this cartifice complataly filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Naturel 1 Tyes 2 🗆 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Hospital 1 / Prifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies 14246 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) SAVOPOULOS, M.D. 2008 MARYLAND HIGHWAY, MT. LAKE PARK, MD 21550 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2001 13083 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** April 6, 6:15A M Allan Sparks /Medical 4c. County of Death 4b. City. Town, or Location of Death 4e. Facility Name (If not institution, give street and number) **Examiner** 3604 Cinnamon Lane Dorchester Linkwood | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 5, 19 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□ F Vrs 215-58-5435 52 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a State 10b. County r then "natural", or items 23e or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Linkwood Directo Dorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21835 3604 Cinnamon Lane U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Pages 1 and 2 should be filed within 72 hours efter Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify white Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) maintenance nursing home 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth eny injury or other traumatic event 2008: Be Edgar Allan Ruark Betty Jane Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Taylor fiancee 23678 King Road, Seaford, DE 19973 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cambridge, MD Dorchester Memorial Park 4/9/04 4 □Donation 5 □ Other (Specify) of Funeral Septe Licensee Thomas Funeral Home P.A. 22. Name and Address of Facility 21. Signature 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Deat 23a. Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of). Examiner ned by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 2 🖸 No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has certificate 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 DNO 2 ER/Outpatient 3 DOA 1 Yes 5 Residence 6 □ Other (Specify) Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funerel Director: the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and awanner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Ligene DD V 2004 Registrar's Signature 31. Date filed (Month, State Registrar

			1 - For State Registrar	State of Maryland / Dep Ce	artment of Health and rtificate of Death	Mental Hygie	. No.
	Physic /Medi Examii	cal	Decedent's Name (First, Middle, Last) Helen Marie 4a. Fecility Name (If not institution, give simple)		4b. City, Town, or Location of Deat	2. Date of Death Month March 2	Day Yeer 5 2004 8:00 A M 4c. County of Death
	Funeral Director		115 Riverview Lane 5. Social Security Number 212-14-4347 Usual Residence of Decedent	M 201 F 7. Age (In yrs. last birthday, 81 Yrs.	Greensboro If Under 1 Year If Under 24 Hrs Months Days Hours Min.		
	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or itams 23e or 28e-f show event. The Modicul Examiner must be rectified at	Funeral Director	10a. State 10b. County Maryland Caroline 10e. Street and Number 115 Riverview Lane	10c. City, Town or Lo Greenst 2. Was Decedent Ever in U.S. 13. Armed Forces?			10d. Inside City Limits 1 ☑ Yes 2 ☐ No Citizen of What Country? U • S • A • 14. Race - American Indian, Black, White, etc.
21215-0036	in 72 hours afte "natural", or i	Completed by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Educ (Specify only highest grade	1 Yes 2	1 ☐ Yes 2 🕅 No Specify: dent's Usual Occupation kind of work done during most of work DO NOT use retired)	161	Specify: White
Maryland 212	should be filed within nd Mental Hygiene. I marked other than "umatic event, the Mar	To Be Comp	Elementary/Secondary (0-12) 7 17. Father's Name (First, Middle, Last) Earl Minner	College (1-4or 5+)	seamstress	ne (First, Middle, Mai	anufacturing den Sumame)
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Men Important: # item 27 is marke any injury or othar traumatic 20028.		19a. Informant's Name/Relationship (Typ June Geib da 20a. Method of Disposition 1 【XBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	aughter 3038 Simoval from State 20b. Place of Dispo	matory or other place)	Dr Cordov Date 200	7a, MD 21625 Location - City or Town, State
Balti	permit. P Departm Importa any injui		21. Signature of Funeral Service Licensed	F P	Name and Address of Facility Tieegle and Helfer	bein Funer	ceensboro, Maryland cal Home PA vland 21639
}	Physician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	Due to (or as a consequence of):	1 // /	wy Disa	Approximate Interval Between Onset and Death Mulaum
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ecords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributes	~ / ^ ·	nderlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Rec		Be Completed	25. Was case referred to medical examiner?		26. Place of Dea	24a. Was an autopsy performed 1 Yes 2 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
DIVISION OT V	ling Phys 1. After this Tuneral dis	Certification; To	1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	ome Residence 28d. Describe how in	6 □Other (Specify) ojury occurred
N	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t		4 Homicide determined	28e. Place of Injury - At home, farm, strebuilding, etc. (Specify) cian: To the best of my knowledge, death	Localized at the time, date and place	City or Town, Sta	/a) and magnetics stated
	To the H within 24 To the Fe complete	Medical	(Check only 2 Medical Examine one) 29b. Signature and title of certifier	or: On the basis of examination and/or invalid and manner stated.	29c. License number	red at the time, date a	Date signed (Month, Day, Year)
			30. Name and address of person who com	CCHS POBOX 12	2 Goldsburg	MD Z	1636
7°.	Sta Registra	- 1	31. Date filed (Month, Day, Year) MAR 3 0 2004	32. Registrar's Signature	of the second		

			For	State of	of Maryland	d / Depa	artment of	Health	and Me	ental Hygi	ene 200	11.	12005
			1 - State Registrar AMEND TIEN		HY C831 5/	/03/ 04 e	tificate o	f Death			g. No.	14	13085
н	Physici	an	Decedent's Name (First, Middle Decedent's Name (First, Middle		_				2	Date of Death Month	_	/ear	3. Time of Death
	/Medi		Robert J 4a. Facility Name (If not institution	ohn Smi			4b. City, Town	or Location		April	3,2004		6:55A [™]
	Examir	ner	Frederick			+ 01	·		or Death		4c. County of		1.
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		Frede	r If Under		B. Date of Birth	Frede		
	Director		187-18-9342	1⊠M 2□F	81	Yrs.	Months Day	s Hours	Min.	(Month, Day, ay 25,			ace (State or Foreign ry) ylvania
	pu >		Usual Residence of Decedent 10a. State 10b. County		10a Cibi	, Town or Lo				<u>,,</u>	1722 11	100.01	7530 113
	laryla shov	2					cation					10	od. Inside City Limits 1 ☐ Yes 2€XNo
	28a-1	Director	Maryland Freder:	ick	Fred	erick	10f. Zip Code			10	g. Citizen of Wh		
	with Sa or			.d D . 1									
	death ms 2	Funerai	8900 Yellow Spr	12. Was Dec	edent Ever in U.S	S. 13. 1	Vas Decedent o	Hispanic Or	rigin? (Speci	fv Yes or No-	United :		
21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "netural", or Items 23a or 28a-1 show avent, the Medical Exams as must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ② Widowed 4 ☐ Divorced	If A no Cit	2 🗌 No ve		fYes,specnfyCu 1□Yes 2□XN			can, etc.)	Specify:	White, e	
9	2 hou	ted	15. Deceden	nt's Education	WII	16a. Deced	lent's Usual Occ	upation		11	6b. Kind of Busin	White	
215	within 7 ene. than "n	Completed	(Specify only higher Elementary/Secondary (0-12)	ost grade completed) College (1-4or 5+)	(Give life. I	kind of work don OO NOT use reti	e during mos red)	st of working	7			,
2	filed withi Hygiene. Ither than	Con	12			Teleco	mmunica	tions	Engin	eer U	.S. Gove	ernme	ent
and		Be	17. Father's Name (First, Middle,					18. Moth	er's Name (i	First, Middle, Ma	aiden Sumame)		
2	should be ind Mental s marked o umatic ave	2	William C. 19a. Informant's Name/Relations	Smith		405 44-10-				McLaugh.			
Maryland	d 2 s th an treu treu			son							City or Town, St		nd 21702
	s 1 and if Health itam 27 other to		20a. Method of Disposition	5011	20b. Pla	ace of Dispo	sition (Name of natory or other p	prings	Dat		Dc. Location - Cit		
e E	- 0 -		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (S		State		n <i>atory</i> or other p. 1 Memori		/6/20		rederick		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sign ture of Funeral Service		1.00						neral Ho	moc	D A
<u>m</u>	80 5 8		NUE	5.60	use	16	21 Opos	sumtow	m Pike	e Frede	rick, Ma	irv1a	and 21702
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that of	caused the death.	. Do not enti	er the mode of d	ing, such as	cardiac or r	espiratory arres	t,	í	Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	a (and	ome	opat	hy				(Onset and Death Years
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	ence of):	1	1					
		<u>-</u> 6	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consequ	ence of):						_	
	uted d ansit	Examine	Cause (Disease or injury that initiated events	<	,								
o,	exectan and and rial-tra		resulting in death) Last	Due to	(or as a conseque	ence of):							
68760,	ficate be executed physician and s the burial-transit	dicai		d									
_	artifica ing ph e as t	G)	IF FEMALE:										
Вох	death certific e attending p id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnan pirth 2 Fetal	death 3□	Ectopic pregnan				23d. Date o		/ Day Year
0		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregn 9⊟Unkno	ant at time of dea own	ath 5∟	Other (specify)				1	J	rour rour
٩	res that the igned by the be detache		Part II. Other significant condition	ons contributing to de	eath but not resul	Iting in the un	derlying cause g	iven in Part I		23e. Did toba	cco use contribu	te to the	cause of death?
Records,	requires leen sign hould be	ed by	Recyr	ent 31	ordy.	Pleur	al E	tus"	n	1 ☐ Yes	2 No 3[] Probat	oly 4 🗆 Unknown
300	aw Is b	ompleted		,			7	4		24a. Was an	24b. Wer	e autops	sy findings available
	о т о С	Com								autopsy performe 1 Yes 2√2	d? deat	r to comp th? Yes 2	oletion of cause of
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					1.7	of Death (C	Check only one)	***		
of Vital	8 o =	2	1 ☐ Yes 2 No			R/Outpatient	JUDON				e 6 Other (Specify)	
		ion	27. Manner of Death 1 Alatural 5 ☐ Pendin		th, Day Year)	28b. Time of Injury		ork?		d. Describe how	injury occurred	-	
Division	l or Attanding after death. Diractor: After in by the fune	ertification;	2 Accident investig 3 Suicide 6 Could d	not be ago Place	of Injury - At hon	ne farm stre		Yes 2 🔲		Location (Stree	et and Number o	v Rum I 6	Pouta Number
Ö	- 0 -	erti	4 Homicide determ	buildii	ng, etc. (Specify)		on idolory, office			City or Town, S		, , , and , ,	(
	To the Hospital or Attend within 24 hours after deati To the Funeral Director: completely filled in by the	Salc	29a. Certifier 1 Certifyin	ng Physicien: To the	best of my know	ledge, death	occurred at the	ime, date an	id place, and	due to the caus	se(s) and manne	or as state	ed,
	in 24 in 24 in 6 in 6 iplete	edical	one)	Exemmet: Ou tue ba	ner stated.	on and/or inv	estigation, in my	opinion, dea	th occurred	at the time, date	and place, and	due to th	ne cause(s)
	To 1 To 1	Σ	29b. Signature and title of certified	r				se number		29d	Date signed (M	fonth, Da	y, Year)
,	10		P		(D ,		DOC	604	17	4	13/20	104	
	10		30. Name and address of person HEMEN 5HA		e of death (Item :	23a) (Type, F	Print)	1600 1		CORNE	21010	1 10	
	Sta	te	31. Date filed (Month, Day, Year)	1	egistrar's Signatu	ite /	3 3000	isori !	り 人 、)	T NEDEK	LICK F	U.	21702
	Registr		APR 0 6		even	19	spor	Es/			PICK M		
_													

		•	For State Registrar 1. Decedent's Name (First, Middle, Last	State of Maryla			nt of H te of L			_	g. No	2004	3086
	Physici /Medic Examir	cal	Regina Tade	elis				Location of		Month March 3	Day 1, 2	Year 2004 County of Death	9:45 A ^M
	Funeral Director		Bradford Oaks I 5. Social Security Number 128 30 3498 10		rs. last birthday) Yrs.		nton or 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Nov 1,	Year)	9. Birth Pola	plece (State or Foreign
	72 hours after death with the Maryland naturel, or items 23a or 28a-f show dical Examiner must be notified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (Ī	City, Town or Lo	9	in Code			1/	Da Citiz	en of Whal Cou	1 Od. Inside City Limits 1 ☐ Yes 2 XX
	eath with the 23 or 2 or 2 or 2 or 2	Funeral Director	10e. Street and Number 4015 William Land 11. Marital Status	12. Was Decedent Ever in	U.S. 13.		ip Code 207		ain? (Spec		Unit	ed Stat	es
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "naturelt, or items 23a or 28a-f show important: if item 27 is marked other than "naturelt, or item and item and item of the page. DDCs.	d by Fun	1 Never Married 2 Married **XX Widowed 4 Divorced	Armed Forces? 1 Yes 2 No li Yes, Give Year or Dates:		1 🗆 Yes	²₹XX ¹ 0	Specify:	, Puerto R	ify Yes or No- lican, etc.)		Black, White,	hite
1215-0	within 72 h iene. ' than "natu	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or 5+)		denl's Usu kind of w DO NOT	rork done d use retired	ation during most)	of workin	g		d of Business/Ir vn Home	dustry
Ĕ	should be filed within nd Mental Hygiene. marked other than imatic event, it a Me	To Be Co	17. Father's Name (First, Middle, Last) Victor Shickma	n				Rou	iche1	(First, Middle, M Wachsb	faiden S erg	Sumame)	
	ss 1 and 2 sho of Health and item 27 ie my r other traumy		19a. Informant's Name/Relationship (T) Florence Segal (Daughter)	4015	Will	iam I	Lane,	Bowi	e, Mary	land		
Baltimore,	t. Pages 1 rtment of Hi rtant: If ites		20a. Method of Disposition 1 Bunal 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Ligans	O.	Place of Dispo cemetery, cre	efior	e Cen	netery		, 2004	Quee	ens, New	York
Bal	Departing Department of the poor in po		* Kol Silv	100 /UDI	340 1	Alexa	ndira	a Ferr	y Ro	ad, Cli	ntor	me,Inc 6 n, Maryl	
	Physician /Medical Examiner	Iner	23a. Parf 1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ne cause on each line. a. Due to (or as a cons	Sold Sold Sequence of):					sirlar a		4/2	Interval Between Onset and Death
	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a cons	sequence of):								
O. Bc	that the death certificate be ex- ied by the attending physician detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)				2	3d. Date of deliv Month	ery Day Year
Q _	sign d be	þ	Part II. Other significant conditions co	,	resulting in the c	underlying	cause give	en in Part I.		23e. Did tob		/	he cause of death? bably 4 Unknown
Vital Records,	The law ate has b page 2 sl	Completed								24a. Was ar autops perform 1 Yes 2	4	24b. Were aule prior to co death? 1 \(\sum \text{Yes}	ppsy findings available impletion of cause of
	> 0 D	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1 ☐ Inpatient 2	! ☐ ER/Outpatie	nt 3 🗆 🖸	OCA Oth	ar /		(Check only only only only only only only only		Other (Speci	(y)
Division of	After After fune	Certification:	27. Manner of Death 1 Najural 2 Accident 3 Suicide 4 Homicide		it home, farm, st	М		yat k? Yes 2 □ N	No	8d. Describe ho 8f. Location (Sti City or Town	reet and	l Number or Rur	al Roule Number,
ā	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer		ysician: To the best of my iner: On the basis of exam and manner stated.									
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		25	9c. Licens	e number 1943))	29	od. Date	signed (Month,	Day, Year)
9	35		30. Name and address of person who	egal My) (Print)	new	Ld 1	#103	77. W	Spi	hy tow	M)2074
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Resistrar's Si	griature.	bed							

			1 - For State Registrer	State of Ma		partment of ertificate o		nd Mental Hyg	giene Reg. No. 2004	13087
	Physic		1. Decedent's Name (First, Middle, La	Taylor	~			2. Date of Dea Month	Day Year U	3. Time of Death 3. P M
	/Medi Examii		4a. Facility Name (If not institution, giv Future Care	@ gruin	gton	4b. City, Town	time	ore i	4c. County of Death	E
	Funeral Director		5. Social Security Number 6. S 579-28-0991	ex	o (In yrs. last birthd 92 Yrs	Months Day		8. Date of Birth Min. (Month, Day Jan. 12	y Year) 9. Birthp County 2, 1912 Wash	lace (State or Foreign try) ington DC
	ow .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				0d. Inside City Limits
	Sa-f sh	ector	Maryland		Baltimo					X □ Yes 2 □ No
	h with th	al Dire	10e. Street and Number 22 South Athol St	reet		10f. Zip Code 21	229		10g. Citizen of What Coun	itry?
936	72 hours after death with the Maryland "naturel", or Itams 23a or 28a-1 show called Executive Court for Invitited at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cu		in? (Specify Yes or No- Puerto Rican, etc.)		
21215-0036	C *	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5	16a. De (G	cedent's Usual Occ ive kind of work don e. DO NOT use retii Homem		of working	16b. Kind of Business/Inc	
	be filed tal Hygid d other event, t	a B	17. Father's Name (First, Middle, Last)		- I			's Name (First, Middle,		TOME
Maryland	rit. Pages 1 and 2 should be filed within artiment of Health and Mental Hygiene critant: if Itam 27 is marked other than nigry or other fraumatic event, The Met.	٥	Robert Henry Rau 19a. Informant's Name/Relationship (19b. Ma	ailing Address (Stree		a Mary Smit	h r, City or Town, State, Zip	Code)
	ges 1 and 2 of Health a if Itam 27 is		Robert A. Taylor 20a. Method of Disposition	- Son		1 Pinefie	1d Circ	cle, Waldor	f, MD 20601	
Baltimore,	Pages net of F int: if Its iry or of	3	1 ☐ Burial 2 ☒ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		cemetery, c	rematory or other pi rematory		-5-04	Waldorf, M	
Balti	permit. Pag Department Important: I arry njury o		21. Signature of Funeral Service Licer	suhaun	00053	22. Name and Add Huntt Fun P. O. box	eral Ho	ome Waldorf, MD		
		82 H	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plicetions that caused one cause on each lin	the death. Do not ne.	enter the mode of dy	ring, such as c	ardiac or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as	a consequence of):	10716	(41	diovasc	ylgr se	Jears -
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due Con	Confes unice of):			9.00		lears
	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
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of Vital Records,		Completed	26 Wassers and a second second						med? prior to con death? 2 No 1 ☐ Yes	sy findings available apletion of cause of 2000 No
of Vit	Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 🗀 Inpatie	nt 2 ☐ ER/Outpat	ient 3 DOA	ther: Nurs	of Death (Check only on sing Home 5 \(\) Reside	ee) ence 6 □Other (<i>Specify</i> ,	
on c	nding Pt th. : After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	y Year) 28b. Time Injur	y W	uryat ork?]Yes 2 ∐N		ow injury occurred	
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (St City or Town	treet and Number or Rural n, State)	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) Certifying Ph 2 Medicel Exen	ysician: To the best of niner: On the basis of and manner sta	examination and/or	ath occurred at the investigation, in my	time, date and opinion, death	place, and due to the can occurred at the time, di	ause(s) and manner as sta ate and place, and due to	ated. the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier	U NOW	ign mi	29c. Licer	155	03 7	9d. Date signed (Month, D	2004
M	Pa		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	e, Print) Do	tphi.	nst-B	alto, MD	21217
	Sta Registr		31. Date filed (Month, DAP R 0)	2004 Regis	ar's Signature	Ande	V)	•	

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JAMES EDWARD TIBBS APRIL 10.2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner T.A.P.I.A.T.A.
If Under 1 Year In Under 24 Hrs. 8. Date of Birth
(Month, Day) CIVISTA MEDICAL CENTER CHARLES 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** NOVEMBER 17,1931 Days Hours Months M 2□ F MARYLAND 72 579-42-8641 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehov 1 Yes 2 □ No Director MARYLAND CHARLES NANJEMOY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a or 13121 RIVERSIDE ROAD 20662 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritat Status 1 Never Married 2 Marned 1 Yes 2 No þ 3 Widowed 4 Divorced BLACK "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) Coltege (1-4or 5+) CHEMICAL PLANT OPERATOR FEDERAL GOVERNMENT 7TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental F 7 ie marked ot JAMES OLIVER TIBBS NELLIE ELIZABETH WASHINGTON TIBBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Pages 1 and 2 ment of Health a ant: If item 27 is NELLIE TIBBS GREER / DAUGHTER 311 WINSLOW ROAD, OXON HILL, MARYLAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Department of Important: If it any injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) OAK GROVE CHURCH CEM APRIL 14, 2004 NANJEMOY MARYLAND 21. Signiture of Funeral Service Lenso THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 THORNTON MO0583 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and **burial** Box 68760 Physician/Medical detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ page 2 should be 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tyes 2□ No 1 Yes Division of Vital 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 1 🔲 Inpatient 32 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D-0008370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ε. PAUL PRITCHETT , MD LAGRANGE AVE. PO BOX1317 LAPLATA, MD20646 118 State Registrar

DA	P		1 - State unpend item#23a,2	State of Maryland	30,20 30,20	artment of	Health an	d Mental Hy	giene	2001	100 0	
			Registrer 1. Decedent's Name (First, Middle, Last)	, , ,	Cel	TITICATE O	Death	2. Date of De	ath		3. Time of Dea	th.
	Physici /Medic		Gregory Adam Tho	orowgood				APRIL	8,20		7:46p	М
	Examin		4a. Facility Name (If not institution, give st 157 WINSLOW PLACE	reet and number)			or Location of D		1	County of Dea	th	
	Funeral Director		210 00 2012 11	7. Age (In yrs. last	Yrs.	If Under 1 Yea Months Day:		Hrs. 8. Date of Bird (Month, Da July 2	$\overset{\text{h}}{4},\overset{\text{h}}{1}$	000	thplace (State or Fo. ountry) aryland	reign
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or litems 23a or 28e-f show that the Medical Examiner must be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Calvert Co	ounty Pri		rederic	S.				10d. Inside City Li	
	with th	Funeral Director	10e. Street and Number			10f. Zip Code			_	izen of What Co	ountry?	
	ns 23	eral	157 Winslow Place 11. Marital Status	2. Was Decedent Ever in U.S.	13.1	20678 Was Decedent of	Hispanic Origin	? (Specify Yes or No-		I.S.A.	erican Indian,	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or Items 23a or 28e-f show event, the Medical Examiner must be notified at	۾	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	'	fYes, specify Cu 1 □ Yes 2🛣 No	iban, Mexican, P	uèrto Rican, etc.)		Black, Whi Specify: Wh		
5	natur	etec	15. Decedent's Educa (Specify only highest grade	ation 1 completed)	6a. Deced (Give	dent's Usual Occi kind of work don DO NOT use retir	upation e during most of	working	16b. Ki	ind of Business	/Industry	
72	withir iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		mfitter	90)		Uni	on Loca	al #602	
2	m 0 5	Be C	17. Father's Name (First, Middle, Last)					Name (First, Middle,		•		
<u>X</u>	should be nd Menta marked	To	Kenneth Wayne Wenl					gie Thorow	_			
Mar	alth ar 11th ar 27 Is r trau		19a. Informant's Name/Relationship (Type Erica N. Thorowgood					r Rural Route Numbe Prince Free				
Baltimore,	es 1 av of Hea if Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Plac	e of Dispo	sition (Name of natory or other pi	ace) Ap	ori ^{Pate} 14,		ocation - City or		
Ē	permit. Pages Department of Important: If It eny injury or o		` 4 ☐ Donation 5 ☐ Other (Specify)	South		Mem. Gar		2004 Lee Funer:			Maryland	
Ba	Depa Impo eny is		21. Signature of Funeral Service Liebnson	4				yland Blv				
>	Physician /Medical Examiner		23a. Part. Enter the disease, or shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Narcotic (Morph Due to (or as a consequent	ine)]			diac or respiratory ar	rest,		Approximate Interval Between Onset and Death	
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al Records,	iician: The law requires that the certificate has been signed by th rector, page 2 should be detache	Completed							sy med? 2 ☐ No	24b. Were au prior to death? 1 Yes	utopsy findings availa completion of cause 2 No	able of
Vita	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	espital: 1 Inpatient 2 ER	/Outpatien	t 3 DOA O	thor	Death (Check only of g Home 5 - Resid		What /Saa	cify) AT SCEN	JE'
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2	To the Hospital or Ai within 24 hours after or To the Funeral Directompletely filled in by	al Certification;	4 Homicide 4 Homicide 29a. Certifier 1 Certifying Physic	28e. Place of Injury - At home building, etc. (Specify) found: residence cien: To the best of my knowle				157 Winsl	n, State W Pl)	nce Frederic	ж,
	he Ho in 24 h he Fui pletely	edical	(Check only 2 Medical Examine one)	er: On the basis of examination and manner stated.	and/or inv	vestigation, in my	opinion, death o	ccurred at the time, o	ate and	place, and due	to the cause(s)	
ij	To t To t	Σ	29b. Signature and title of certifier	M			nse number			e signed <i>(Mont</i> L 9,200		
			S.R. 1406	pleted cause of death (Item 23	1	Print) 11 Penn	Street,	Baltimore	e, M	aryland	21201	
- 17	Sta Registr		31. Date filed (Month, Day Year) APR 13	32. Registre's Signature	K	South	D .					

			- For	State of Maryland / Dep	artment of Health and	•	e .
			1 - State Registrar		rtificate of Death	Reg. N	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) $John$	Taylor, Jr	•	2. Date of Death Month D March 2	3. Time of Death 3 : 15 P M
	Examin		4a. Facility Name (If not institution, give s Prince George's		4b. City, Town, or Location of Dea Cheverly		c. County of Death rince George's
	Funeral Director		5. Social Security Number 6. Sex 217-60-9170	7. Age (In yrs. last birthday) M 2 F 51 Yrs.) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplece (State or Foreign Country) Maryland
	Maryland B-f show	stor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar	10c. City, Town or L	ocation Tracys Landin	g	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3e or 28	i Direc	10e. Street and Number 103 East Bays	side Road	10f. Zip Code 20779	10g. C	Citizen of What Country?
920	be filed within 72 hours after death with the Maryland tal hygiene. od other than "natural", or items 23e or 28e-f ahow event, the Mcdistal Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ KNo	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 🌠 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	1 within 72 hor piene. r then *natura the Medical E	ompleted	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) 1 2		odent's Usual Occupation e kind of work done during most of wo DO NOT use retired) ruck Driver	orking 16b.	Kind of Business/Industry Local Government
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	nd 2 salth ar		19a. Informant's Name/Relationship (Ty) Robert Taylor/E	Brother 621			ngton, D.C. 20011
Baltimore,	Page ent o nt: If ry or		20a. Method of Disposition 1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Cooper's	osition (Name of matory or other place) s UMC Cem. 4/3	/04 D ₁	Location - City or Town, State
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	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Fatal Card:	terthe m <i>o</i> de <i>of</i> dying, such as cardia iac Arrhythmia	c or respiratory arrest,	Approximate Interval Between Onset and Death
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8760,	ate be execute hysician and the burial-tran	cai	resulting in death) Last	Due to (or as a consequence of):		a property of the control of the con	
.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not resulting in the u	underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Minknown
of Vital Records,		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vita	.i. 8 6	Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Others	ath (Check only one)	
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Division	or Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, sti building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir one)	sicien: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place exestigation, in my opinion, death occ	e, and due to the cause(urred at the time, date ar	s) and manner as stated. Id place, and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1	29c. License number D46591		ate signed (Month, Day, Year)
	2		30. Name and address of person who co Ndubuisi Achu	ompleted cause of death (Item 23a) (Type,	Print)		
) Sta	te -	31. Date filed (Month, Day, Year)	20 Desistation Cinneture	Soulis	enarden, M	20700
	Registr	ar	MAR 3 1	20104 Magree 15	ROSAGE B		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Tyler Rosetta 10:05A M Apri1 2004 /Medical 4a. Facility Name (If not institution, give street and number) 3559 Yellow Bank Road 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Calvert Dunkirk | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Dec. 5, 1930 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □XF 213-26-8223 73 Yrs. Maryland Director Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-1 ahow any injury or other traumatic event, the Mudical Examiner round by multiple an once. 1 ☐ Yes 2 X No Maryland Calvert Dunkirk Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3559 Yellow Bank Road 20754 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Someone Else's College (1-4or 5+) Domestic <u>Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alston Janie Lee Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugenia Stepney/Daughter 906 Augustus Dr. Prince Frederick, MD 20678 20b. Place of Disposition (Name of commetery, crematory or other place)
Young's Cemetery 4/8/2004 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Huntingtown, MD * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 Sevell Dlady a. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Small Onset and Death CARCINOMA tmmediate Cause (Final disease or condition resulting in death) CELL OF **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list continuations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit physician and Due to (or as a consequence of) Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetat death in the past 12 menths?
1 Yes 2 No
9 Unknown detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig. 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural
2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No s after death. investigation the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 02965 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Judge, Prince Frederick, MD20678 M.M. 31. Date filed (Month, Day, Year) 32. Registra Signature State APR 06 2004 Maria. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Lours **Physician** MARch 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mercy Hospital n/a Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🐼 F 87 214-20-4016 Director August 11, 1916 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director n/a Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or 124 West Franklin Street 21202 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Africanþ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care other 17. Father's Name (First, Middle, Last) permit Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any in lury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin Thomas Ada Bell Ogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Great-William A. Harris, Jr. /Nephew 4449 Mountville Rd., Frederick, MD 21703 20b. Place of Disposition (Name of cometery, crematory or other place)
Sunnyside U.M. Church 20a. Method of Disposition March 15, 20c. Location - City or Town, State 1 ⊠Surial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Frederick, Maryland Cemetery 21. Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody. P.A. Catoctin Mtn. Hwy. Frederick, MD 21701 232 Part Enter the disease, or co shock, or heart failure. List on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onsel and Death Immediate Cause (Final disease or condition resulting in death) **Physician** espirator /Medical Examiner P515 'e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? è 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resultingfin the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe merten sin 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Xnpatient 2 ER/Outpatient 3 DOA After this 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) I in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Nafne and address of person no completed cause of death (Item 28a) (Type, Privil)

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State Registrar evins W

MAR 16

2004

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Dhysisian	1. Decedent's Name (First, Middle	e, Last)				-	2. Dete of I Month	Deeth Dey	Yeer	3. Time of Death
Physician /Medical	BARBARA ELLEN	THOMPSON					April	2	2004	0927
Examiner	4a Fecility Neme (If not institution	-				4b. City, To	wn, or Location of De	eth 4c. Coun	ty of Death	
	PENINSULA REG				If Under 1 Year		ISBURY	WIC	OMICO	
ral tor	5. Social Security Number 216-30-4180	6. Sex 1 □ M 2 🖺 F	7. Age (In yrs. 69		Months Days		Min. JUNE	Birth Pay, Year 13, 1934	MARY)	lace (State or Foreign LAND
	Usual Residence of Decedent		10- 0		-12					
_	10a. Stete 10b. County			y, Town or Lo					119	0d. Inside City Limits 1 X Yes 2 □ No
Sct	MARYLAND WICOM	100	SH	ARPTOW				10.00		
급	10e. Street and Number 207 STATE STRE	ਹ ਾ			10f. Zip Code 2186	1		10g. Citizen of USA		try ?
Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U	S. 13. V			gin? (Specify Yes or I		ce - America	an Indian.
듄	1 Never Merried 2 Man	Armed F ried 1 ☐ Yes	orces? 2 🔼 No	1	Yes, specify Cul	ban, Mexican	i, Puerto Rican, etc.)		ack, White, e	
Þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I		1	☐ Yes 2 No	Specify:		Speci	ity: WHI	TE
Completed		t's Educetion st grade completed)	16e. Deced	ent's Usual Occu	ipation	t of working	16b. Kind of I	Business/Ind	lustry
힐	Elementary/Secondary (0-12)		(1-4or 5+)		kind of work done OO NOT use retire	ed)	· · · · · · · · · · · · · · · · · · ·	()[N HOM	7
ဒ္ဓ	8 17. Father's Neme (First, Middle,	I and		HOME	AKER	10 Math	er's Name (First, Midd		N HOMI	<u> </u>
Be	ROBERT LEE SIR	•					A VIRGINIA		mej	
၉	19a. Informant's Name/Relations			19b Mailin	n Address (Stree		er or Rural Route Nun		n State Zin	Code)
	WILLY M. THOMP		ND	1	•		ARPTOWN, M			0000)
	20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of		Date	20c. Location		wn, State
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		FIREMEN		4/6/200	4 SHARPT	OWN. N	MARYLAND
	21. Signature of Funeral Service		11	22	Name and Addr	ess of Fecilit	v	1		
	Dan Much	13	eller	1			HOME, P. (m 21802
1	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death							Approximate
	, shock, or heart failure. List	only one cause on	eech line.						i	Interval Between Onset and Death
	Immediate Cause (Final disease or condition				Sepsi	ς				
.	resulting in death)	a	Due to (o	r as a conseq						
Examiner		a b			EMPH	YSEM	A			5 years.
хап	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying		Due to (o	r as e consequ	uence of):					
a E	ceuse. Enter Underlying Cause (Disease or injury that initieted events	C							i	
edicai	resulting in death) Last		Due to (or	as a consequ	ience of):					
Physician/M		d								
icia	Part II. Other significant condition	ns contributing to d	leath but not resu	ulting in the un	derlying cause gi	iven in Part I.	23b. Di	d tobecco use co	ontribute to	the cause of death?
hy		•		•				Yes 2 No		ably 4 Unknown
by										
								is an autopsy formed?	ava	re autopsy findings ilable prior to
Completed									of d	npletion of cause leath?
Son							10	1 Y99 2 1 No	10	Yes 2□ No
Be	25. Was case referred to medical examiner?		/		T ₂		of Death (Check only	one)		
2	1 ☐ Yes 2 ☑ No		Inpatient 2		3LI DOA		rsing Home 5 Re)
Certification:	27. Manner of Deeth 1 ☑Naturel 5 ☐ Pendin	9	of Injury oth, Day Year)	28b. Time of Injury	28c. Inju Wo M 1			now injury occu	rred	
cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be	a of Injury . At ho	me farm ot-]Yes 2□N		(Street and Num	her or Pural	Route Number
ertif	4 ☐ Homicide determ	ined 288. Plece build	e of Injury - At ho ing, etc. (Specily	nne, rarm, stre	et, lactory, office			own, State)	υσι υι ⊓uïal	riodio radiribar,
	29a. Certifier 1 Certifyin	g Physician: To the	best of my know	vledge, death	occurred at the ti	ime, date en	d place, and due to th	e cause(s) and m	anner as ste	ated.
edicai	(Check only 2 Medical one)	Examiner: On the b	asis of examinat iner stated.	ion end/or inv	estigation, in my	opinion, deat	th occurred at the time	, date end place,	end due to	the cause(s)
Me	29b. Signature end title of certifie				29c. Licen	se number		29d. Date signe	ed (Month, D	Day, Yeer)
	Inde Nato				Do	51359	ā	April	2201	2004
-	30. Neme end address of person	who completed caus	se of death (Item	23e) (Type, F				110,441		
	Usha Natesen 1415 S	- DIVISION	- 1	HISBU	RY MO	21804				
	31. Date filed (Month, Day,	D O C 289:15	egistrers Signal	ure 2.	1 .	,				

			For State Registrar	State of Man	•	•	nt of Heal		, ,	iene iene 200	14 1309
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last Cheryl G. Tropf 4a. Facility Name (If not institution, give	=		4h Cih	y, Town, or Loca	tion of Dooth	2. Date of Death Month March	Day Year 31, 2004 4c. County of Dea	3. Time of Death 4: 42р м
	Examin Funeral Director	ier	Gilchrist Center 5. Social Security Number 6. Se	:	n yrs. last birth		Towson		8. Date of Birth (Month, Day, 10/15/	Baltimo	
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Howard	10	oc. City, Town Highl					1.7-10	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the 23a or 28a ust be not	ral Director	10e. Street and Number				20777			og. Citizen of What C	
036	ours after der all, or Items Examination	by Funeral	11. Marital Status 1 Never Married 22 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.		edent of Hispani ecrty Cuban, Me 2 X No Spe	c Origin? (Spe xican, Puerto F ecify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic event, Ite Mudical Examinatings to notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(most of workin) g	16b. Kind of Business Self	Andustry Employed
yland 2	tould be filed Mental Hygi narked other	To Be C	17. Father's Name (First, Middle, Last) Frank R.Griffit	hs			18. N	Shirle	y Magn		
	C		19a. Informant's Name/Relationship (T) William J.Tropf		130	060 St.	Patric	k's Cou	rt High	City or Town, State, land, Md.20)777
Baltimore,	9°= 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of D cemetery, Metro	crematory or Cremat	other place)	4/1/2	2004	Catonsvill	e,Md.
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Incens	nato moo	845					zke's Fami icott City	ly F.H.Inc. ,Md.21043
pm by	Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ications that caused the ne cause on each line. a. Due to (of as a color). Due to (or as a color).	wph onsequence of	ic (0):		scardiac or		st,	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	ical	resulting in death) Last	Due to (or as a co	onsequence of):		-			
(04 € 0. Box	Attending Physician: The law requires that the death certifica r death. r death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 1 □ Yes 2 □ 1 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown]Fetal death	3 □Ectopic 5 □ Other (23d. Date of de Month	livery Day Year
3(3)	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but n	ot resulting in t	he underlying	cause given in F	Part I.	23e. Did toba	acco use contribute to	the cause of death?
ai Reco	n: The law ra icate has be r. page 2 sh	Completed								prior to death? No 1 □ Yes	utopsy findings available completion of cause of
OPF Chery 3/	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	dospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outp 28b. Tin	ne of	Othor	Nursing Hom	(Check only one te 5 ☐ Resider 8d. Describe how	200	city) flospice
ROPE	il or Attendi after death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm Specify)	M n, street, facto	1 ☐ Yes		8f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
1	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier Certifying Phy (Check only one)	sician: To the best of mer: On the basis of exand manner stated	amination and/	death occurre or investigation	d at the time, dat on, in my opinion,	e and place, ar death occurre	nd due to the car d at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	wp		_	9c. License numl			d. Date signed (Mont	
DO 0	2		30. Name and address of person who co	ompleted cause of death	(Item 23a) (T	ype, Print)	harres	ST 30	alt mon	emp 217	404
1	Sta Registr		31. Date filed (Month, Day, Year) APR 0 2 20	32. egistrar's	Signature	Sperk	j)				,

		1 - State Registrar	State of Maryland / Depa	rtificate of Death	Reg. N	- 711111	+ 1309				
Physic	ian	Decedent's Name (First, Middle, Last, EDWARD)		TORRES	2. Date of Death Month C	ay Year	3. Time of Death 1652 A				
/Med Exami Funera Director	ner	4a. Facility Name (If not institution, give The Johns Hook 5. Social Security Number 8. Se	ins Hospital	4b. City, Town, or Location of Death Bultimore City If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	lc. County of Deal					
44	Director	Usual Residence of Decedent 10a. State 10b. County DE New Cas 10e. Street and Number	_	gton 10f. Zip Code		Citizen of What Co	10d. Inside City Limit 1 ☐ Yes 2 N untry?				
el', or items 23a or 28a-f show Examirer must be notified at	by Funeral	1516 Seton Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed ADDivorced	12. Was Decedent Ever in U.S. Armed Forces? 1YTYes 2 □ No	19809 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ▼No Specify:	pecify Yes or No- o Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White					
Hygiene. other then "naturel", ent, the Medical Exe	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	e completed) (Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) utor Programme	king	efrig. N	_{Industry} Manufatro				
nd Mental Hygiene. marked other then matic svent, the M	To Be C	17. Father's Name (First, Middle, Last) Francisco To		Dolo	ne (First, Middle, Maide res S. Ro	senthal					
permit. Pages 1 and 2 should be filed within 72 ho Department of Healin and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		19a. Informant's Name/Relationship (T) Dolores S. Mai 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lieths	Sel - Mother 151 Removal from State 20b. Place of Disponsional Removal from State R. A.	sition (Name of	ilmington Date 20c. il 5, 200 ry Wes	Location - City or t Chest	9809 Town, State				
The law requires that the death certificate be executed XE We will a support the attending physicien and a support the support to a support the support to a support the support to a support the support to a support the support to a support the support to a support the support to a support the support to a support the support to a support t	cal Examiner	23a. Part1. Enter the disease, or compile thoris that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Its drift one cause on each line. Immediate Cause (Principle of the cause of the ca									
been signed by the attending phy should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	ivery Day Year				
been signed b	þ	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause grven in Part I.	23e. Did tobacci 1 ☐ Yes 24a. Was an	2 ⊠ No 3 □ Pr	othe cause of death? obably 4 Unknow utopsy findings availab				
r this certificate has	te Completed	25. Was case referred to medical		26. Place of Dec	autopsy performed? 1 ☐ Yes 2 25 h ath (Check only one)	death?	completion of cause of				
ifter death. Director: After in by the fune	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 November 2 Accident 3 Suicide 6 Could not be determined	Abspital: 1 X Inpatient 2 ☐ ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury 28b. Place of Injury - At home, farm, strength	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in 28f. Location (Street City or Town, Sta	jury occurred and Number or Ri					
within 24 hours a To the Funeral C	edical Ce	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place exestigation, in my opinion, death occurred	a, and due to the cause arred at the time, date a	(s) and manner as and place, and due	stated, to the cause(s)				
within To the	Me	29b. Signature and Itle of certifier	Ree	29c. License number		Poll ,					
6		30. Name and address of person who o	ompleted cause of death (Item 23a) (Type, Johns Hopkins Hospita	Print)	street Balti	more MD	21287				

State of Maryland / Department of Health and Mental Hygiene 2 0 0

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Jnknown	04-079
04-1866	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

6		1 - For State Registrar	Glate Of Maryla	Cen	tificate of L	Death		gierie Z. H. H. L. Reg. No.	10090				
Physicia		Decedent's Name (First, Middle, L.	unkno	own			2. Date of Dea Month		3. Time of Death				
/Medic Examine		4a. Fecility Name (If not institution, ga 5504 Livingsto			4b. City, Town, or Oxon Hi			4c. County of Dea	820 a The Georges				
Funeral Director		Social Security Number A Usual Residence of Decedent	45384 0535	rs. last birthday) nown Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 1		thplece (State or Foreign				
Maryland a-f ehow	tor	10a. State 10b. County	nown 10c.	City, Town or Loc	ation Jnknown				10d. Inside City Limits				
th with the 23e or 28 unt be not	al Director	10e. Street and Number unk	nown		10f. Zip Code unknow	m		10g. Citizen of What Co	ountry?				
ours after dearal; or items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2½ No If Yes, Give Year or Dates:	If	as Decedent of Hi Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, Whit Specify: B.	e, etc.				
I within 72 ho iene. r then "natui the Wedical	Completed	15. Decedent's to (Specify only highest governmentary/Secondary (0-12)	Education rade completed) College (1-4or 5+) N/A	(Give k	ent's Usual Occupa ind of work done d O NOT use retired, Infant	ition luring most of work)	king	16b. Kind of Business	/Industry				
ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Las Un]	t) Cnown			18. Mother's Nam Unkne		Maiden Sumame)					
t. Pages 1 and 2 shr trment of Health and trant: If item 27 is m jury or other traum		Mr. Troy Harding	(Detective)	12603	Brunswi	ck Lane	Bowie, M	r, City or Town, State, . Aaryland 20	715				
		20a. Method of Disposition 1- Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	ify)	esurrect	tion (Name of atory or other place ion Cemet	tery 20	004	20c. Location - City or Clinton, Ma	aryland				
Departing Departing Support Su		21. Signature of Funeral Service Lice	1 MOO 543	L 66	33 01d A	lexander:	ia Ferry	l Home, Inc Road Clint	con, MD20735				
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. A Sphyxia and hypothermia. Due to (or as a consequence of):											
executed an and rial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):											
rificate ng phy: as the	Physician/Medical	d											
e igne	ò	9 □Unknown Part II. Other significant conditions	contributing to death but not r	esulting in the und	lerlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?				
	Completed						24a. Was an autops perform	ned? prior to death?	topsy findings available completion of cause of				
Physician: The this certificate al director, page	lo Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 DOA Other	26. Place of Deat		e) ance 6 x ⊡Other <i>(Spe</i> c	at scene				
Attending I death. octor: After by the funer.	Certification;	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not determined	OB Class of lains. At	home, farm, stree	1	at	28d. Describe ho Subject po	ow injury occurred lace d in plas oilt sides reet and Number or Ru	the belg and				
ital ralled		29a. Certifier 1 ☐ Certifying P	hysician: To the best of my ki	nowledge, death	dure	e date and place	and due to the ca	5504 Divivo	stated.				
Mithin 24	Medical	29b. Signature and title of certifier	miner: On the basis of examination and manner stated.	nation alloyor inve	29c. License			ate and place, and due 9d. Date signed (Month					

State Registrar

31. Date filed (Month, Day, Year)
APR 0 1 2004

30. Name and address of persor who completed cause of dea (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

OCME

March 16 2004

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3*0* March 2004 4:02 Samantha M. Underwood /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Calvert Manor Health Care Rising Sun Cecil 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2 X F 213-74-9471 98 December 9,1905 VA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Hyglene. Items 23a or 28e-f ehow other traumatic event, the Macinal Exemples mail to notified as other traumatic event, the Macinal Exemples in mail to notified as 1 ☐ Yes 2 No Director MD Cecil North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 108 Willard Drive 21901 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Δ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Earl Mercer Nannie Leola Hough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Heelth and Important: If item 27 is m any injury or other traum 900.0. Kenneth B. Underwood/Son 119 Inglewood Drive, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 04-01-2004 1 X Burial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) Calvary Baptist Cemetery Rising Sun. MD 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licenses 111 S. Queen Street, Rising Sun, MD 21911 esa. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inmediate Cause (Final disease or condition resulting in death) HROMBDEMBOLIC **Physician** ARGE /Medical Due to (or as a consequence of) Examiner FIBRULATION - PAROXYSMAR ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) PE No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown Completed peen SUCKINGULT HIS GER TO PORTY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ②K No 24a. Was an certificate 1 Yes 28 No Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 41X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 💢 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death After t 5 Pending investigation 128 Natural 1 ☐ Yes 2 ☐ No death. I Director: A 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 | Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier H0058419 MARCH 31, 2004 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) 1881 TEREGRAPH ROAD RISING SUN MD 21911 Y340c DONHAM, D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State (Desce Registrar APR 2004

State of Maryland / Department of Health and Mental Hygiene? 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Catherine Virginia Vogt 18 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITAL HEART ALLEGANY SACRED LUMBERLAND If Under 24 Hrs. If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Aug 9, Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 212-05-6201 1 ☐ M 2 🙀 F Mary Land 88 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23e or 28e-1 show 10a. State 10b. County 10c. City, Town or Location ir than "natural", or itams 23a or 28a-f show the Medical Examinational be notified at 10d. Inside City Limits MD Harford Bel Air Funeral Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 E Church Hill Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Completed by Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 12 th Pharmacy traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is markad William Kinnersley ပ Elizabeth Lemmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 itam 27 othar tra John H. Vogt, Jr./son 716 Hillcrest Drive, Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Country Side Crem. Mar. 20,2004 Davidsville, PA 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A., PO Box 275 Kumaei 179 Miller St., Grantsville, MD 21536 23a. Part1. Enter the disease, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death Bilatera Immediate Cause (Final **Physician** (6mmunity disease or condition 4 days resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dua to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending phy. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Dav Year 5 Other (specify) funeral director, page 2 should be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Olmpr3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hipatient 2 ER/Outpatient 3 DOA Certification: To shis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To tha Funaral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35 12ma 10 th (Item 23a) (Type, Print) 30. Name and address of person will mpleted cause of 70M45 un 31. Date filed (Month, Day) 32. Registrar's Signature 2004 Registrar

			for State	State of Marylan				ental Hygiei	ne	
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	Physici	an	1. Decedent's Name (First, Middle, La	INCENT				2. Date of Death Month	Pay Year	3. Time of Death J
I.	/Medic		4a. Fecility Name (If not institution, giv		41	. City. Town. or I	ocation of Death	2	4c. County of Death	1904 "
	Examir Funeral Director	ler	UNIVERSITY 07 5. Social Security Number 0 6. S 222-22-2144	F MARYLAX Sex 1 Tuge (In yrs.	DO ME	DICK	If Under 24 H/s. Hours Min.	0 0	ZTIMO 9. Birth	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Locati	on				10d. Inside City Limits
	h the Maryland r 28a-f ehow Incititied at	tor	DE Kent	F	larringto	on				1 ☐ Yes XXNo
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	ath wi		16396 S. DuPont	Highway		19952		Un:	ited Stat	es
Maryland 21215-0036	d within 72 hours after death with the Maryland Jione. r than "natural", or Items 23s or 28s-f ehow The Medical Example must be natified at	by Funeral	11. Marital Status 1 ☐ Never Married 2⅓ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	If Ye	s, specify Cuban,	panic Origin? (Spe , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
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ary	S D E E		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	ddress (Street an		Route Number, Cit		ip Code)
Baltimore, M	permit. Pages 1 and 2 should Department of Health and Mer Important; If item 27 ie marke eny injury or other traumatic once.		Betty M. Vincent 20a. Method of Disposition VXBurial 2 Cremation 3	Removal from State	lace of Dispositio	n (Name of ry or other place)	Di I	4	ton, DE Location - City or T	
Hir	iit. Pa irtmer injury injury		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licer	110-	lywood (emetery		2004 Har	rington,	DE
Ba	permit. Departn Imports eny inju		Thomas 2 1	11.0			-	DuPont Hw	w Harri	agton DF
	Physician /Medical Examiner ithe prijativansit	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	vsloi		respiratory arrest,		Approximate Interval Between Onset and Death
.O. Box 68760	the death certifi y the attending ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	I death 3 □Ect	opic pregnancy ner (specify)			23d. Date of deliv	rery Day Year
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ğ	law requires as been sign 2 should be	ted t	CONGESTIVE	neart	taill	IVE		1 🗆 Yes	2 No 3 □ Pro	bably 4 □Unknown
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Ζ̈́		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ 1√0	Hospital:	ER/Outpatient 3	□ DOA Other:	26. Place of Death		4 DO:	
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			30. Name and address of pesson who	completed cades of pleath-flieng	23a) (Type, Print	ex)D1	MEDIC	59 3/c	NITED	
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	s		Decedent's Name (First, Middle, Last)	2. Date of Deal	th _	3. Time of Death
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Ì	Examin	er			4c. County of Deat	h'
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	fanyla stor	ŏ				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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	ems 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispan Mr. Armed Forces?	nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No 3 ☐ Widowed ₩ 2 1 ☐ Yes 2 ☑ No Year or Dates:	pecify:		hite
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<u>></u>	Physician: The Is r this certificate ha ral director, page 2	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 [☐ Nursing Home 5☐ Resider	nce 6 Other (Speci	fy)
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,			30 Name and address of person who completed cause of death (Item 23a) (Type Print)	241 NGUY	FM 8	1 FC 63
Di	33		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAI-C	21044	en, Mi	, , , , ,
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State of Maryland / Department of Health and Mental Hygien 2 0 0 4 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Pay **Physician** Berman Walton Weeks April 2004 7:36A /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 917 Francis Scott Key Highway Keymar Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 14, 1927 Mary land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 ☐ F 76 213-24-8236 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any niury or other traumatic event, The Medical Examinar must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XXYes 2 No Maryland Carroll Directo Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 917 Francis Scott Key Highway 21757 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2X☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) heating/air condition-College (1-4or 5+) Elementary/Secondary (0-12) heating technician installation&serv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harley W. Weeks Maisie Reed 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene E. Weeks/ wife 917 Francis Scott Key Highway Keymar, MD 21757 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 4/7/2004 nr. Linwood, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licensee attarine 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute MI disease or condition resulting in death) 10 Min. /Medical Due to (or as a consequence of) Examiner CAD 10 Yes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) inding physician and use as the burial-transit The law requires that the death certificate be executed DM II Exam 20 Yrs. resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atten for u 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 4 Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ۵ 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide ă To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number D20330 4/5/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Lehigh 104 N. Main St. Union Bridge, MD 21791 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2004 Registra

State of Maryland / Department of Health and Mental Hygiene 🥎 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:15 p Christine Louise Waldvogel April 6, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner La Plata ff Under 1 Year Charles 614 Hickory Circle If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 ☐ M 2 💢 F Yrs 58 3/13/2004 Director CT 213-46-8269 Usuet Residence of Decedent with the Maryland 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at 10a. State 10b. County 10c. City. Town or Location. 10d. Inside City Limits 15 Yes 2 □ No Funeral Director La Plata Charles MD 10f. Zip Code 10g. Cifizen of What Country? 10e. Street and Number 20646 <u>USA</u> death <u>614 Hickory Circle</u> 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mertal Hygione. and if item 27 is marked other than "natural", or ite inty or other traumatic avent, the Modific Resulting to the traumatic avent, the Modific Resulting to the traumatic avent, the Modific Resulting 1 ☐ Yes 2 X No ff Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 <u> Antique Shop</u> Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ Louise May Gregory Rernard Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1940 E. 63rd Street, Sioux Falls, SD 57108 Beverly Waldhalm/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. *4 □ Donation 5 □ Other (Specify) 4/10/2004 Alexandria, Virginia Metropolitan Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Raymond-Wood Funeral Home, P.A. boo PO Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat **Physician** DUNG disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy sate has been signed by the atte-page 2 should be detached for it Day 4☐Pregnant at time of death 5 Other (specify) Ó 9 Unknown 9 Unknow م Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To 3□ DOA 5 Residence 2 ER/Outpatient 6 ☐Other (Specify) this Manner of ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by 4 - Homicide pellil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan BOY 1703 Mb. Mather, 6.0. 31. Date filed (Month, Day, Year) 32. Registra/s Signature State 2004 Registrar

		For State Registrar	State of Marylar		artment of H rtificate of L			Reg. No. 200			
Physicia /Medica Examine	al -	1. Decedent's Name (First, Middle, Last) Steven Edward 4a. Facility Name (If not institution, give to Calvert Memorial I	Windsor, S	r.	4b. City, Town, or	Location of Deat	h	Day Yes 3, 2004 4c. County of D	11:29a		
Funeral Director		5. Social Security Number 6. Security Number 220-74-8374 Usual Residence of Decedent	7. Age (<i>In yrs.</i> IM 2□ F 46	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	 8. Date of Bir 	th ly, Year)	Birthplace (State or Forei Country) aryland		
or 28e-f show	Director	10a. State 10b. County Maryland Calvert 10e. Street and Number		ntingt				10g. Citizen of What	10d. Inside City Limi 1 ☐ Yes 2√∑ N Country?		
ritems 23s	by Funerai D	5210 Surrey Cour 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1	1	206 Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No		Specify Yes or No to Rican, etc.)	Black, W	merican Indian, Thite, etc. vhite		
within 72 ane. then "na	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occupa kind of work done of DO NOT use retired,	luring most of wo)	rking	16b. Kind of Busine	ss/Industry		
Mental H arked ott	To Be C	17. Father's Name (First, Middle, Last)	Windsor, Sr.			18. Mother's Na Faye	Elinor	, Maiden Sumame) Hutchins er, City or Town, State	on		
of Health fitem 27 r other tr		Bonnie L. Windsor 20a. Method of Disposition 1 Burial 2 Type matrion 3 P	wife 20b. I	5210 Place of Disponentery, cre	Surrey Consistion (Name of matory or other place	ourt, Hu	ntingtov Date	vn MD 206 20c. Location - City	39 or Town, State		
permit. Fag Department Importent: I any injury o once.		`4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licens	elbart.	R R	tan Crema ^{2. Name and Addres} ausch Fund	s of Facility eral Hom	e, P.A.,	Alexandri	•		
ysicia ysicia	licai Examiner	cai	ca	23a. Part1. Enter the disease, or complishock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	nce of): hemic	To key	Diseas	eathy		Interval Between Onset and Death
ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	aldeath 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year		
been signed b should be deta	۾	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	inderlying cause give	in in Part I.			to the cause of death?		
ate has page 2	e Compieted	25. Was case referred to medical					1 Tes	osy prior death 22No 1 🗆 Y			
shis la	10 B	examiner?	ospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time of Injury	of 28c. Injury Work	r: 4 ☐ Nursing H	-	dence 6 Other (S	pecify)		
Tospiled of Americans 124 hours after death. 16 Funerel Director: After letely filled in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	fy)			City or Tov				
	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	sician: To the best of my knoner: On the basis of examina and manner stated.	ation and/or in	29c. License	inion, death occu	irred at the time,	cause(s) and manner date and place, and cause and place, and cause signed (Mc	lue to the cause(s)		
	е	30. Name and address of Jison who come Mark J. Kushner, 31. Date filed (Month, Day, Year)		spital	Print)		Frederic	ck, MD 206	78		

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 0400 AM **Physician** WENNER 2004 EMILY YARCH /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Baltimore City

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

July 22 1912 Examiner 7. Age (In yrs! last birthday) HOPKINS JOHNS Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Lovettsville VA 1 ☐ M 2 🛛 F 91 Yrs 220-30-9807 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic avent, the Medical Examina must be notified at 1 X Yes 2 ☐ No Brunswick Frederick Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 21716 1201D Maple Terrace Apartments #403 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 13 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 X No Specify: Specify: Baltimore, Maryland 21215-0036 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Loudoun County School College (1-4or 5+) Elementary/Secondary (0-12) Cafteria Worker Board 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Estelle Cooper Norman Llewelyn Werking 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2516A Jefferson Pike, Jefferson, MD 21755 Sandra Tucker, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot orce. 1 Burial 2 □ Cremation 3 □ Removal from State 3/22/2004 Lovettsville, VA * 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 21. Significate of Funeral Service Licensed 22. Name and Address of Facility John T. Williams Funeral Home WI1 Wams, 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Abdominal Aortic 10 days Aneurysm **Physician** /Medical Due to (or as a consequence of): Examiner Hypertension 110000 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? throw bounto penia autopsy performed? 2 No 1 Yes 1 Yes 2 🔯 No or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier House RES-000 18,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. TONG; THE JOHNS HOPKINS HOSPITAL 1600 N. WOLFE STREET: BALTIMORE, MD 21287 31. Date illed (Month, Day, Year) 32. Registrar's Signature State Registrar MAP 9 9 200

		•	For State Registrar	State o	f Marylan		artment of Hortificate of E		ental Hygie Reg	ne .No. 200	4 13105	
		_	1. Decedent's Name (First, Midd	le, Last)					2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic	al			lley				April	7 200	/	
	Examin	_	4a. Facility Name (If not institution				4b. City, Town, or		· '	4c. County of Dea		
			Dorchester (5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	ridge If Under 24 Hrs.	8. Date of Birth	Dorche 9.Bi		
	Funeral Director		213-22-8154	150 M 2□F	7. 75	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) NOV. 27	1928	rthplace (State or Foreign Country) Maryland	
		ŀ	Usual Residence of Decedent									
	how		10a. State 10b. County		10c. Cit	y, Town or Lo		mbasi das			10d. Inside City Limits 1 XYes 2 □ No	
Ç	e Ma 3e-f s	cto		chester				mbridge	1.0			
K	with th	Dire	10e. Street and Number 216 Meteor Av	70 7\:0+	908		10f. Zip Code	613	109	IOg. Citizen of What Country? U.S.A.		
2	s 23e	erai			edent Ever in U	.S. 13.	Was Decedent of His If Yes, specify Cubar		pecify Yes or No-	14. Race - Am	nerican Indian,	
Maryland 21215-0036 🧳	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other traumetic event, I're Medical Evantian must be notified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☑ Divorce	rried 1 X Yes	orces? 2∐No ive ταπαλ		If Yes, specify Cubar 1 ☐ Yes 2 📈 No	Specify:	Rican, etc.)	Black, Wh	white	
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and	12 should be filed within "n and Mental Hygiene." I'ls marked other then "raumetic event, the Me.	Be	Dorsey J. Wil						s Hilda B			
Ž	d Me d Me mark metic	2	19a. Informant's Name/Relation			19b. Maili	ng Address (Street a		ral Route Number, C		Zip Code)	
Ma	id 2 s lith an 27 ls		Doris Murphy		ster		-		st New Ma		21631	
ē,	s 1 and 2 f Health item 27 l		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place			c. Location - City o	or Town, State	
ê	Pages nent of int: If it		1 ⊠Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (State		•		4/12/04	Hurlock,	MD	
Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service	Licensee		2:	2. Name and Addres	s of Facility	Thomas Fu	neral Hon	ne P.A.	
a	8 9 E 8 8		Brian K. I	Lutin					ambridge,			
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that it only one cause on	caused the deat each line.	th. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death	
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	/Medical Examiner		resulting in death)	Due to	(or as a consec	juence of):						
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P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregn birth 2 Feta gnant at time of on nown	al death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year	
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00	aw reis bee	piet							24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of	
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ita	ician: Th certificate ector, pag	Be	25. Was case referred to medic examiner?						ith (Check only one)			
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isic	Attending r death. ector: After by the fune	icat	3 Suicide 6 □ Coul		ce of Injury - At h	ome, farm, si	reet, factory, office	100 2			Rural Route Number,	
Division of Vital Records,	e after I Direct d in by	Certification;	4 Homicide dete		ding, etc. (Speci		,		City or Town,	State)		
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	To the within To the comp	Ň	29b. Signature and title of certification	Elen).M		29c. Licens	6 3 8 8	8 A	Date signed (Mo	nth, Day, Year)	
				n who completed ca				Ave. H	ırlock, M	21643	,	
	St	ate	31. Date filed (Month, Day, Ye.	32.	Registrar Sign	ature						
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryla	•	tificate of		ReRe	ig. No. 2	004 13	
Dharini	1. Decedent's Name (First, Middle, Las	it)				2. Dete of Death Month		3. Time of De	
Physician /Medical	Esther Kief	er Watts				April		2004 4:45	
Examiner	4a Fecility Neme (If not institution, give	street end number)			4b. City, Town, or I	ocation of Deeth	4c. County of	of Deeth	
	Ruxton Health	of Denton			Dent		Caro	line	
Funeral Director	030-24-0900	ex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Dey, 4-6-19		9. Birthplece (State or Fr Country) Germany	
Pu *	Usuel Residence of Decedent 10e. Stete 10b. County	10c. C	City, Town or Loc	cation				10d. Inside City L	
Aarya Or	DE Kent		Hartly					1 ☐ Yes 2	
ect see	10e. Street end Number	,	патсту	10f. Zip Code		10	ng. Citizen of W	het Country?	
	1743 Hourglass	Pond			9953		USA		
# 23	11. Maritel Stetus	12. Was Decedent Ever in	U.S. 13. V			pecify Yes or No-		- American Indian,	
permit reages 1 and 2 should be lied within 2 hours ener death with the maryland Department of Health and Mentie Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates:		Yes, specify Cub	Hispenic Origin? (Span, Mexicen, Puerling Specify:	o Rican, etc.)	Specify:	white, etc. White	
ted ted	15. Decedent's Ed	ucetion	16e. Deced	ent's Usual Occu	petion	kina	16b. Kind of Business/Industry		
Die Man	(Specify only highest green Elementery/Secondary (0-12)	College (1-4or 5+)			during most of wor ed)				
Die Property of the Property o	12		В	ookkeep	er		Accoun	nting	
Se spirit	Bookkeeper 12 Bookkeeper Accord 18. Mother's Name (First, Middle, Last) Albert Kiefer 19e. Informant's Name/Relationship (Type, Print) step Lynn A. Frankton/daughter 190e. Method of Disposition 200e. Method of Disposition 1 Buriel 23C Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 201. Signature of Funeral Service Licensee 102 Bookkeeper Lina Maier 19b. Mailing Address (Street end Number or Rurel Route Number, City or Table Place of Disposition (Neme of Cemetery, Cremetory or other plece) Kent Cremation Serv. 3, 2004 Smg 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pippin Funeral Service Licensee 22. Name and Address of Facility Pippin Funeral Service Licensee				faiden Sumeme	e)			
smarked of umatic eve	Albert Kiefer	•			Lina	Maier			
and he	19e. informant's Name/Relationship (7	ype, Print) step	t end Number or Ru	rel Route Number,	City or Town, S	Stete, Zip Code)			
alth alth	Lynn A. Frankto			733 Hog Lot Rd., Ridgely, MD 21660					
of Hand		20b.	Place of Dispos	sition (Neme of netory or other ple	ece)	Date 2	20c. Location - 0	City or Town, State	
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The rate has been age.						1 🗆 Ye	s 2 No	1 ☐ Yes 2 ☐ No	
certificate rector, pag	25. Was case referred to medical				26. Place of Dea	th (Check only on	e)		
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arth nerel	27. Menner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	ury at	28d. Describe ho	w injury occurre	əd	
eth. r: Aft ne fur	1 ☐ Naturel 5 ☐ Pending 2 ☐ Accident investigation		,-,		Yes 2□No				
by the	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (St. City or Town		er or Rurel Route Numbe	
	7,5110000	building, etc. (Spec	··· y/			, 0. 70	/		
hours hours y fille		ysician: To the best of my kr							
n 24 n 24 ne Fu sletel	(Check only 2 Medical Exam	niner: On the basis of examinend manner stated.	nation end/or inv	estigation, in my	opinion, death occu	rred et the time, da	ue ena piece, a	ino oue to the cause(s)	
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29b. Signeture end title of certifier				se number			(Month, Dey, Year)	
) /J U/\ n	hun		1 4	27926		4/2 ln	004	
	30. Neme end eddress of person who o	completed cause of deeth (Itr	em 23e) (Type, I	Print)	3236 Draw (A 1			
	(34) SAM	~ 210	D,	Dunh	Bran (huh, M	40 2/1	619	
State	31. Dete filed (Month, Day, Year)	32/Registrar's Sign	<u> </u>						
Pogietrar	APD _ 5 200	A Second	All Pass	2000					

1	4	For State		State of Ma	aryland		artment of F		Mental Hy	/giene Reg. No	0001	
Dhusisis		Registrar 1. Decedent's Name (First, Middle, Last			061	tilicate of t	Dealit	2. Date of De	eath Da	y Year	3. Time of De
Physicia /Medic	ai -	Richard M					4b. City, Town, o	Location of Dea	MARCH	28	2004 County of Death	2100
Examin	21	PENINSULA 5. Social Security Num	REGIONAL 6. Se	MEDICAL	e (In yrs. las	st birthday)	SALISB If Under 1 Year Months Days		s. 8. Date of B	idh	WICOMICO	nplace (State or Fo
Director		196 36 93 Usual Residence of D 10a. State 1	00		57	Yrs. Town or Lo	cation		August	21,1	946 Gern	10d. Inside City L
r 28a-f aho	rector	10e. Street and Numb			North	East	10f. Zip Code			10g. Ci	tizen of What Co	1 Yes 2
permit Fages I and a Should be little which is a hour arise death will the way justed beauther of Health and Mental Hygiene. Important: if I lem 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, if the Medical Examinur roual be notified at once.	by Funeral Director	35 Butterf 11. Marital Status 1 Never Married		12. Was Decedent Armed Forces? 1 Yes 211			Was Decedent of H	an, Mexican, Pue	Specify Yes or N	n, etc.) Black, W		ncan Indian, a, etc.
natural', o	eted by	3 Widowed 4		If Yes, Give Year or Dates: location le completed)		16a. Dece	1 ☐ Yes 2 XNo dent's Usual Occup kind of work done	during most of we	orking	16b. K	Specify: White . Kind of Business/Industry	
ygiene. ner than "	Completed	Elementary/Second	lary (0-12)	College (1-4or 5 4		Machi:	nist		ame (First, Middle		ospace]	Industry
ental H	o Be	17. Father's Name (Fi						Marie 3		a, maider	(Sumame)	
alth and Me 27 Is mark r traumati	To	19a. Informant's Nam Jean Wojc	ne/Relationship (T)				ng Address <i>(Str</i> eet utterfiel					
tment of Heartant: If Item		`4 □Donation 5	Cremation 3 □I		20b. Pla May	erdal	estion (Name of matory or other place e Cremato		il 3, 2004	New	ark, Del	
Depar Impor any ir		21. Signature	Service Licens			1	2. Name and Addre	ss of Facility C1 Main Sti	rouch Fu	nera	1 Home	71and 210
hysician /Medical Examiner		Immediate Cause (Fi disease or condition resulting in death)	failure. List only o	a. Mult Due to (or as	a Conseque	2 7	njune					Interval Betwee Onset and Dea
ysician and	edical Examiner	Sequentially list conditionly, leading to limit cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	st	Due to (or as Due to (or as				4-14-				
y the attending physician Iched for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 9	onths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3	Ectopic pregnancy	,			23d. Date of deli Month	ivery Day Yea
gned b be deta	by	Part II. Other signific	ant conditions co	ntributing to death b	out not result	ting in the u	inderlying cause giv	ren in Part I.			~1	the cause of dea
ate has been si page 2 should	Completed								24a. Wa auto peri 1X Yes	s an opsy formed? 2 \square	death?	topsy findings ava completion of cause
certifica	BeC	25. Was case referre	-						eath (Check only	one)		
this aldi	6	1 X Yes 2 □ N 27. Manner of Death	0	Hospital: 1 Inpatie	ent 2 E	PVOutpatie		4 Nursing			6 □Other (Spec	
r death. ector: After by the funer	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28a. Date of Injury 28b. Time of Injury at Work? 3 Suicide 6 Could not be determined 28b. Time of 28c. Injury at Work? 1 Yes 2 Kno 1 Yes 2 Kno 28c. Place of Injury - At home, farm, street, factory, office 28f. Location (Str							(Street a	nd Number, or Ru	Iral Route Numbe	
within 24 hours after d			☐ Certifying Phy	sician: To the best					new S	muth e cause(s	s) and manner as	
within 24 I	Medical	one)		iner: On the basis o and manner st		on and/or in	29c. Licens		Surreu at the time		ate signed (Monti	
with To con	~	29b. Signature and	Mix	W				OCME			RCH 29,	
10		30. Name and address	ss of person who	ompleted cause of o			enn Stree	+ Dal++	imore M	arevi.	and 2120	.1

DHMH 17 Rev 1/2001

Registrar

1 2004

Amend]	[te	m	18 4/9/04	Please	Type or Pri	int in E	Black	Indelib	le Ink.	Ensure .	All Copie	s Are	Legibl	e.	
Cecil Cou	int	У	For KP Stata Registrar	State of M	larylan	Contificate of Death									
			Registrar 1. Decedent's Name (First	Middle La	et)			Citino	ile Oi	Death	2. Date of	Reg. N	lo.	3.7	ime of Death
Phy	sicia	_	GEORG	_	ROBE	DT	Va	lins '	iAM	502	Month		ay Y	991	= 36 PM
the state of the s	ledica	_	4a. Facility Name (If not in							Location of Dea			c. County of		- 361
Exa	amine	} {	HARFORD				TAI	1		REDE			HAR		
Fune	aral		5. Social Security Number	6. S	ex 7. A	ge (In yrs.	ast birtho	lay) If Uni	der 1 Year	If Under 24 Hr	ST 9 Data of	Dieth			State or Foreign
Direc			078-14-7427	7 1	△ M 2□ F	8	37 Yrs	Month	s Days	Hours Mir	May 1	Day, Yea	922	Country)	Ny
9			Usual Residence of Dece			1.0									
arylar	4	_		County				r Location							side City Limits Yes 2 No
88f.		Sct	MD	Cecil	<u> </u>	C	oloro					T			
with the		2	10e. Street and Number		,				Zip Code				Citizen of Wha	at Country?	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-f show	1	To Be Completed by Funeral Director	244 Nesbit	t Koac	1 12. Was Deceden	t Ever in II	c .		1917	liannaia Origin? /	Specify Ves es		USA 14 Page	American Inc	line
ler de		Ş	11. Marital Status 1 ☐ Never Married 2	Marriad	Armed Forces	?	3.	If Yes, s	pecify Cuba	lispanic Origin? (an, Mexican, Pue	rto Rican, etc.)	140-		White, etc.	idii,
)36 Irs at		ò	3 ☐ Widowed 4 ☐ D		WVan Chin	If Yes, Give Year or Dates: WW II			X□ No	Specify:			Specify:	White	
2 hou	183	ed	15. D	ecedent's Ed	ducation		16a D	ecedent's U	sual Occup	ation		16b.	Kind of Busir	ess/Industry	
215 Pin 7.		be	(Specify only Elementary/Secondary		College (1-4or	5+)	lii	fe. DO NOT	work done i use retired	during most of we	orking				
o filed with	5	ĕ		(0 10)	3	/	<i></i>	ldmini	strat	or			Teleph	one Co	mpany
nd e file lothy	ven (ge (17. Father's Name (First, i							18. Mother's Na					
/an Ment Ment		2	George Wil	liams	on										elhors
Baltimore, Maryland 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. mporiant: If them 27 is marked other then "natural", or	other treumatic event, fre N		19a. Informant's Name/Re							and Number or F			or Town, Sta	ite, Zip Code,)
Baltimore, Ma permit. Pages 1 and 2: Department of Health at Important: If item 27 is	19 Tel		Althea M.		amson	1				Road,			21917		
Ore pes 1 of Hiter	to la		20a. Method of Disposition 1 X Burial 2 ☐ Cren		Removal from State	20b. P	lace of Di emetery,	isposition (for crematory of	vame of or other place	(e) 04-	10-2004	20c.	Location - Ci	y or Town, Si	ate
Pag Pag	À		° 4 □ Donation 5 □ C	Other (Specif	y)	we	st No			emetery			Colora		
Salt ermit.	any in		21. Signature of Funeral S	Service Lie	1See			22. Name	and Addre	ss of Facility R	.T. Foa	rd Fo	uneral	Home,	P.A.
m go =	8 O		11-9							een Str			Sun,		
			23a Part 1. Enter the dise shock or heart failui	ease, or com re. List only	plications that cause one cause on each	ed the death line.	n. Do not	enter the m	ode of dyin	g, such as cardia	ac or respiratory	arrest,		Appro	oximate val Between et and Death
Physic			Immediate Cause (Final disease or condition		a	1-1 a	SC	UD						Olise	t and Death
/Medi Exami			resulting in death)	•	Due to (or a										
		_	Sequentially list condition	s,	b. Due to (or a										
108	lisii .	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ite 【	Due to (or a	s a consequ	uence oi).								
a secut	urial-transit	xan	that initiated events resulting in death) Last	- 1	c. Due to (or a	s a consequ	uence of):								
8760, cate be exphysician	5 .	_													
6876 difficate by	eg :	g		•	d								-		
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and	use a	Physician/Medica	IF FEMALE:		23c. If yes, outcom	e of pregna	ncy						23d. Date of	f delivery	
Box eath cer	jo .	clar	23b. Was decedent pregrin the past 12 month		1 ☐ Live birth 4 ☐ Pregnant	2 Fetel	death	3 Ectopic 5 Other					Month	Day	Year
O. 5 4	perto.	ysi	1 □ Yes 2 □ No 9 □ Unknown		9□ Unknown										
cords, P.O.	deta	by P	Part II. Other significent of	conditions o	contributing to death	but not resi	ulting in th	ne underlyin	g cause giv	en in Part I.	23e. Di	d tobacco	use contribu	te to the caus	se of death?
Records, ne taw requires the has been signed	e :										1[Yes	2 □ No 3 (Probably	4 🛣 Unknown
CO	shor	Completed									24a. W	as an	24b. Wei	e autonsy fin	dings available
Re he ta	page 2	Ĕ									au pe	topsy rformed?	prio dea	r to completion th?	on of cause of
Vital F	ed .	ပိ	25. Was case referred to	medical		·				OS Blace of Do	1 Yes		lo 1 🗆	Yes 2 18 N	0
Sicies Sicies	S 1	∞	examiner?	medical	Hospital: 1 ☐ Inpat	ient 2 🖼	EŔ/Outpa	atient 3	Oth	0.0	eath <i>(Check onl</i> Home 5 - Re		€ □Othor	Consitu)	
Phys of	ar 1	2	27. Manner of Death		28a. Date of In (Month, D		28b. Tim	e of	28c. Injun Wor		28d. Describ			Specily)	
Division of Attending Fatter death.	<u>.</u>	Certification;	1 XNatural 5 ☐ 2 ☐ Accident	Pending investigation		ay Year)	Inju	ry M		k? Yes 2 □No					
risio Attendi	th the	fice	3 Suicide 6 🗆	Could not be	28e. Place of II			, street, fact	ory, office		28f. Location	(Street a	and Number	or Rural Route	Number,
Division Attended	E D	ert	4 Homicide		building, e	etc. (Specif)	/)				City or i	own, Sta	te)		
Hospitel	y tille	a	29a. Certifier 1□ C	ertifying Ph	ysicien: To the bes	t of my kno	wledge, d	eath occurr	ed at the tin	ne, date and place	e, and due to th	e cause(s) and manne	er as stated.	
the Ho	etel.	Medical	(Check only 2 N	fedicel Exer	niner: On the basis and manner s	of examination	tion and/o	r investigati	on, in my o	pinion, death occ	urred at the tim	e, date a	nd place, and	due to the ca	iuse(s)
Divisic Division To the Hospitel or Attend within 24 hours after death To the Funerel Director:	dwoo	ž	29b. Signature and title of	certifier					29c. Licens	e number		29d. D	ate signed (A	fonth, Day, Y	ear)
			Yann	alt.	who	_ 1	M. 0		D	21809		AN	ML 6	,200	24
ha on		Ì	30. Name and address of	person who	completed cause of	death (Item	23a) (Ty	pe, Print)							
104	8		GS PRA	340	M.0	23	36	401	LIC 1	NO T	IMON	in	n mo	210	13
	Stat		31. Date filed (Month, Day	y, Year)	32. Regis	trar's Signa	ture								
Re	aistra	ir	APR = 8 20	NY A	(Walley .)	74 4	08.00	1							

			For State Registrar	State	of Ma	aryland	d / Depa <i>Cer</i>	irtment o <i>tificate d</i>	f Heal of Dea	ith and ath	Mental	Hygie Reg.	ene2001	\$	13109
ı	D		1. Decedent's Name (First, Middl	e, Last)							2. Date	ot Death	Day Yea		3. Time of Death
	Physicia /Medic			Ruth	Sea	ay Ad	ams				APR		25, 200		7:50 a M
	Examin		4a. Fecility Name (If not institution Millennium of	n, give street and n Ellicott	u <i>mber)</i> Ci	ty		4b. City, Tow E11		ation of Deat t City			4c. County of De Howa		
	Funeral Director		5. Social Security Number 220-07-2858	6. Sex 1 ☐ M 2X7 F	7. Ag	e (In yrs. la	a <i>st birthday)</i> Yrs.	If Under 1 You Months Da		Jnder 24 Hrs ours Min	(Mor	of Birth th, Day, Yo Y 15.	ear) 9. E	Birthplac Country	e (State or Foreign) 1 Carolina
	p ,		Usual Residence of Decedent			,	, Town or Lo	nation					, = ,		. Inside City Limits
	anyla shov	7	10a. State 10b. County Maryland Balti											100	1 Yes 2 No
	the M	ect	Maryland Balti 10e. Street and Number	llore		ETTT	cott (10f. Zip Coo				100	. Citizen of What	Country	
	death with the Maryland oms 23a or 28a-f show ir must be notified at	Funeral Directo	778 Hollow Roa	d				2104					SA	,	
	death ms 2	nera	11. Marital Status	12. Was De	cedent	Ever in U.S	S. 13. V	Vas Decedent	of Hispan	ic Origin? (S	Specify Yes	or No-	14. Race - Ar		
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show appring to other traumatic event, Ite Medical Executive must be published at once.	by Ful	1 XNever Married 2 Mar 3 Widowed 4 Divorced	If Yes. G	2 X	No	i	f Yes, specify (I ☐ Yes 2【X		exican, Puer vecify:	to Hican, e	ic.)	Specify:	nite, etc	White
5	72 ho	ted	15. Deceder (Specify only highe	t's Education	r)		16a. Deced	lent's Usual Oc	cupation	most of wo	nkina	16	b. Kind of Busine	ss/Indus	stry
N	ithin ne.	Completed	Elementary/Secondary (0-12)	College	-	i+)		kind of work do DO NOT use re	tired)	y 111031 07 W	, All 19		~~~~~i	- 1	
7	led w tygier her th		12	(act)			Secre	etary	10	Mothode No.	mo /First I		Commercia	a1	
/land	ntal H ed ot	Be	17. Father's Name (First, Middle,										iden Sumame)		
	hould d Me mark matic	၉	James Barney S 19a. Informant's Name/Relations				19b. Mailin	a Address (Str		essie Numberor <i>R</i>			City or Town, State	. Zio Ci	ode)
<u>8</u>	nd 2 s lith ar 27 is r trau		Robert Kent Ad					Hollow						1043	,
ē,	os 1 and 2 of Health item 27 i		20a. Method ot Disposition			20b. Pla		sition (Name o		1	Date		c. Location - City		
Ē	Page nent o int: If iry or		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		n State			ematory		. 4-2	7-04	E	Baltimor	e, N	ÍD -
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service	Jan March	ma	ld	22	Name and Ac Cremati 299 Fre	dress of On So	Facility OCIETY	of M	D, Ir	nc. imore, M) 2	21228
ľ			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that	caused	the death.								A	pproximate terval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. A7	467	थ्य ५०	-	one		ERI	BRO	VAS	CUHAK		nset and Death
	Examiner			Due to	o (or as	a consequ	ence or):								
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as	a consequ	ence of):						>		
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	- 1									4	
Ď,	cate be executed physician and s the burial-transit	al E	rossing in assim, saoi	Due to	o (or as	a consequ	ence or):								
09/80		dicai		d											
XOE	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o									23d. Date of d	lelivery	
	death	icia	in the past 12 months? 1 Yes 2 DNo	4☐Pre	gnant at	2 Fetal time of de		Ectopic pregna Other (specif)					Month	Da	ay Year
J.	at the by the	hys	9 🗆 Unknown	9□ Unk											
ras,	law requires that the death certifias been signed by the attending 2 should be detached for use as	by	Part II. Other significant conditi	ons contributing to	death b	ut not resu	Iting in the ur	nderlying cause	given in	Part I.	23e		cco use contribute	robab	
Hecord	2 2 2	ompieted									24a	. Was an autopsy	24b. Were	autopsy	findings available letion of cause of
	The ate h page	Com									1 🗆	performe	d,? death	? es 2(
Vitai	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?							Place of De	ath (Check	only one)			
0	ys is	7	1 Yes 2 No		Inpatie		R/Outpatien			Nursing I			e 6 ∏Other (S	oecify)	
	ng fter ne	tion	27. Manner of Death 1 Natural 5 Pendi	28a. Dat igation (Mo	onth, Da	y Year)	28b. Time of Injury		njury at Work? 1 ☐ Yes	2 □ No	200. Des	CLIDS HOW	injury occurred		
UIVISION	Attend death ctor: y the	ertification:	3 Suicide 6 Could	not be 28e. Place	ce of Inj	ury - At hor	me, tarm, str	eet, factory, off					et and Number or	Rurai F	oute Number,
2	at or Attending P s after death. Il Director: After id in by the funera	erti	4 Homicide	buil	ding, et	c. (Specify,)				City	or Town, S	State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C		ng Physician: To the Examiner: On the and ma		f examinati									
	ro the vithin ro the complex c	Me	29b. Signature and title of certific	2	4			29c. Lic	ense nun	nber		29d.	. Date signed (Mo	nth, Da	y, Year)
	- > - 0		Januar	in Yeu	2le	ar.		1)	280	75			4/26/6	4	
	1		30, Name and address of person	who completed ca		leath (Item	23а) Туре,	Print)			TYE .	BA	tero M	1) 6	21208
	Sta Registr		31. Date filed (Month, Day, Year APR 2 7	32.		ar's Signat	ure	Spark	2	- '				-	

			1 - For State Registrar	State o	f Marylar		artment of F		d Mer		jiene .eg. No.	2004	13110
		r.	Decedent's Name (First, Middle,	Last)						Date of Dea	_		3. Time of Death
	Physici		Gail L	. Appleg	ate					APRIL	24°	, 2004 ^{ar}	9:32 p м
}	/Medic Examin		4e. Fecility Name (If not institution,				4b. City, Town, o	r Location of D	eath		4c.	County of Deet	1
	LXamin		10524 Dickens	Wav			Wc	odstocl	k			Howa	ard
_	Funeral			. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 l	Hrs. 8.	Date of Birth	Vanal	9. Birth	plece (State or Foreign
	Director		135-36-8919	1□M 2√F	58	Yrs.	Months Days	Hours N	Vin.	(Month, Day JULY 1	4. 1		Jersev
			Usual Residence of Decedent										
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Man-feh	to	Maryland Baltime	ore	Wo	odstocl	ζ						1 ☐ Yes 2 No
	179 1289	Director	10e. Street and Number				10f. Zip Code			1	0g. Citia	zen of What Co	untry?
	Sa or		10524 Dickens Wa	av			21163			1	USA		
	i within 72 hours atter death with the Maryland jiene. r then "natural", or tleme 23a or 28e-f ehow the Medical Estiminer mast be notified at	Funerai	11. Marital Status		edent Ever in U	J.S. 13. V	Vas Decedent of H	lispanic Origin?	? (Specify			14. Race - Ame	ncan Indian,
_	ter d	L L	1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?	'	f Yes, specify Cuba	an, Mexican, Pu	uerto Ric	an, etc.)		Black, White	e, etc.
20	hours after tural', or ite al Exemine	byl	3 ∑Widowed 4 □ Divorced	If Yes, Gir Year or D	ve Z		1□ Yes 2∏ No	Specify:				Specify:	White
12-0036	tura i	ed	15. Decedent's	Education		16a. Deced	lent's Usual Occup	ation			16b. Kir	nd of Business/I	ndustry
C	in 72	ojet	(Specify only highest	grade completed)	4.4	(Give	kind of work done OO NOT use retired	during most of d)	working				
7	filed within 72 Hygiene. Ither then "nat Int, the Medic	Completed	Elementary/Secondary (0-12)	Coll e ge (1-40r 5+)	Cleri	ca1				Off	ice	
2	Hyg Hyg Int.	C	17. Father's Name (First, Middle, La					18. Mother's	Name (F	irst, Middle, i			
<u>a</u>	0 0 0	To Be	William Applega	te				Arline	≥ Foi	ırnier			
_	2 2 2 2	Ĕ	19a. Informant's Name/Relationship			19b. Mailir	g Address (Street				City of	Town State, Z	in Code)
Mar	tra tra		Marc W. Applega				Dickens			stock	-		
a)	s 1 and f Health ftem 27 other tr		20a. Method of Disposition	ce/ bori	20b.		sition (Name of natory or other place		Date			cation - City or	
ຼັ	r of		1 ☐ Burial 2 ☐ Cremation 3		State	_							
Baltimore,			*4 □ Donation 45 □ Other (Spe	-	Me		ematory I		-27-0		Ва	ltimore	, MD
g G	permit. Departr Import any inji		21. Signature of Faneral Service Li	7.740	Malel	2	Name and Addre	Şociet	ty of	MD,	Inc.		
	20210		Dawn F. Mc	Donald			199 Frede	rick Ko	oad	Balt:	lmor	e, MD	21228
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that only one cause on e	aused the dea each line.	th. Do not ent	er the mode of dylr	ig, such as care	diac or re	spiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. 11	STES	TINI	94 (DBST	RU	CTI	ON)	4 months
	/Medical		resulting in death)	Due to	(or as a conse	quence of):							
	Examiner		Sequentially list conditions,	b. 78	RIT		AL	ME-	TA	STF	158	55	4 YEARS
	D #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):	a ^		. ^				11.000
	cute nd trans	Examiner	that initiated events	c	OLE	NC _	CA	NCE	12				2 TEARS
Ď,	e exe ien a urial-	Ä	resulting in death) Last	Due to	(or as a consec	quence of):							
8760	law requires that the death certificate be executed as been signed by the attending physicien and should be detached for use as the burial-transit	dicai	33	d									
0	ng ph	Med	IF FEMALE:										
X R O	eath certific attending p	/ue	23b. Was decedent pregnant		tcome of pregn pirth 2 Fet		Ectopic pregnancy	,			2	3d. Date of deli	
	deal	sicie	in the past 12 months? 1 Yes 2 No		ant at time of		Other (specify)					Month	Day Year
j	at the de by the	Physician/Me	9 🗆 Unknown		· · · · · ·								
	es that igned b	by F	Part II. Other significant condition	s contributing to d	eath but not re	sulting in the u	nderlying cause giv	en in Part I.		23e. Did tol	bacco u	se contribute to	the cause of death?
Ö	w require been si	ed							_	1 🗌 Ye	es 2%	No 3□Pro	bably 4 Unknown
Records,	s be	Completed							Ī	24a. Was a		24b. Were au	opsy findings available
	o ~ B	E							_	autops perform	ned?	death?	ompletion of cause of
Vital	sician: Th certificate rector. pag	0	25. Was case referred to medical	2				26. Place of	Death /C		2 No	1 103	20110
	Physician: this certifica	To B	examiner? 1 ☐ Yes 2 ∑ No	Hospital:	Inpatient 2] ER/Outpatien	t 3 DOA Oth			5 Reside		☐Other (Spec	ifv)
Division of	Attending Physician: if death. ector: After this certific by the funeral director.		27. Manner of Death	28a. Date	of Injury	28b. Time of				. Describe ho			
<u></u>	After a fun	ţ	1 Natural 5 Pending 2 Accident investiga		th, Day Year)	Injury		k? Yes 2 □ No					
<u> S</u>	Attendi	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place	of Injury - At h	nome, farm, str	eet, factory, office		28f.	Location (St	reet and	Number or Ru	ral Route Number,
á	after after Dire	Certification:	4 Homicide	build	ing, etc. (Speci	ity)				City or Town	n, State)		
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the	best of my kn	owiedge, death	occurred at the tir	ne, date and pl	ace, and	due to the ca	ause(s)	and manner as	stated.
	HG 124 Pu	Medical	(Check only 2 Medical Ex	caminer: On the b and man	asis of examin ner stated.	ation and/or in	estigation, in my o	pinion, death o	occurred a	at the time, d	ate and	place, and due	to the cause(s)
	ro th Withir To th	ž	29b. Signature and title of certifier		11	118	29c. Licens	e number		2	9d. Date	signed (Month	, Day, Year)
	Δ		> Low	021k)	I To	cum	> > >	236C	16		41	2610	54
	4	5	30. Name and address of persen w	no completed cau	of death life	23a) (Type,	Print) /		۸		V (,	-
			11065 little	Pater	eut la	Yun	~ (HAIN	Ma	MI) _	210	144 9	Educad J. Lee
	Sta	ite	31. Date filed (Month, Day, Year) APR 2 7 2004	32. F	Registrar's Sign	atore		dis.			, -		A
	Registr	ar	APR 2 7 2004	Level	Man A	S A	males						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 For State
Registrate FND TIEM #24a&26 PER VERB C830 4/27 Gertificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day 25 A M Month Year Physician 2004 ames /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 Good Somaritan Saltimore Mospita If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** M 2□F Months G liag 089 05 349 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be putified any once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State LETes 2 □ No Completed by Funeral Director BM HINCE MAYAMA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USB 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: B/cck Year or Dates: WWI Specify: Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Settlehen Steel Elementary/Secondary (0-12) College (1-4or 5+) Warles 4 EAYS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7234 ORH 182E 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition + Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation _5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility d Ha 240 Leis TEX Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute cebrovascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No certificate 1 ☐ Yes To the Hospital or Attending Physicien: Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 EFVOutpatient ٩ 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 2 ☐ Accident Injury 5 Pending 1 □ Yes 2 ∏No death. I Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) title of certifier License number 29b. Signature and eleted cause of death (Item 23a) (Type, Print) Boulevard Loreck, David Kaven 3900 Loch 31. Date filed (Month, Day, Year)
APR 2 7 2004 2. Registrar's Signature State Registrar

		•	For State Registrar AMEND TIFM #2	State of Mar					nd Me		giene 2	004	1311
	ysicia Medica	n al	1. Decedent's Name (First, Middle, Las. James George Ange	n laras					-	2. Date of De Month	eath Ou-OS	004	3. Time of Death 10:38 A N
	amine		4a. Fecility Name (If not institution, give Washington Advent 5. Social Security Number 6. Se	ist Hospita	In yrs. last birthday	Tak	oma P	ark If Under 2		R Date of Bir	Mont	gomers	/
Fund Direct				ZM 20F 7	9 Yrs.	Months		Hours	Min.	B. Date of Bir (Month, Da March1	6, 192	5 Gree	plece (State or Foreig ntry) PCE
e Marylan	Illied at	ctor	10a. State 10b. County MD Prince Ge		Oc. City, Town or L Laurel						-		10d. Inside City Limits 1 ☐ Yes 2 🔀 No
auth with the	oust be no	rai Di	7700 Cherry Lane	10 Was Dandont Ev	as in H.S. 12	20	p Code 707	ia Osiai	-2/0	4. Va Na	USA	of What Cou	
72 hours after death with the Maryland natural; or Itams 23s or 28s-1 show	Examiner	ò	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Opproced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	erin U.S.	If Yes, spe			Puerto Ri	ify Yes or No ican, etc.)		Race - Ameri Black, White, ecify: W	
	the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+) 5+	(Give		ork done d ise retired)	tion uring most o ineer		7	Civil	& Str eering	uctural
nd 2 should be filed withir th and Mental Hygiene. 27 is marked other than	atic event,	To Be C	17. Father's Name (First, Middle, Last) George Angelara	as					's Name (First, Middle Sakis	, Maiden Sun		
ges 1 and 2 sho t of Health and if item 27 is m	ther traum		19a. Informant's Name/Relationship (T. George Angelana 20a. Method of Discosition	as / son	1307 20b. Place of Disp	Cree!	kside	Driv			Spring 20c. Location		0904
permit. Pages 1 a Department of Heal Importent: if Item	_		1 XBurial 2 Cremation 3 □1 4 □ Donation S □ Other (Specify, 21. Signature of Hintra/S) rvice J en	Removal from State	Greek Orth	odox C	other place emeter		/10/0)4	Woodla	•)
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death certificate be executed Exam e attending physicien and	ne burial-transit	icai Ex	resulting in death) Caquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a control of the contr	consequence of): RES consequence of):	VEM	i A						~ 10 de
death certific e attending p	ched for use as	Physician/Med	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 { 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	□Ectopic p □ Other (s)						Date of deliving	ery Day Year
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of or Attending s after death. il Director: After	completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (· At home, farm, si					f. Location (S City or Tox		imber or Rura	al Route Number,
To the Hospitel or Atl within 24 hours after d To the Funerel Direct	pietely fille	edicai	29a. Certifier (Check only one) 1 Certifying Phy	ysician: To the best of r iner: On the basis of ex and manner stated	camination and/or in	th occurred nvestigation	at the time	e, date and inion, death	place, an occurred	d due to the at the time,	cause(s) and date and plac	manner as s ce, and due to	tated. o the cause(s)
To ti withi To ti	lwoo	Ň	29b. Signature and title of certifier	arty				178			29d. Date sig	9-04	
			30. Name and address of person who c		7.	Print)	COT	TAGE	Ci	TY,	MD :	2072	2
Re	Stat gistra		31. Date filed (Month, Day, Year) APR 2 7 2004	32. Registrar's		door	(2)						

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		Physici /Medic		Decedent's Name (First, P)	Middle, Last) hyllis			And	drews			2	2. Date of De Month		Day 2004	Year	3. Time of Death 0645 M
		Examir		4a. Facility Name (If not inst			mber)		4b. City		Location of I	Death		4	tc. County o		ce
		Funeral Director		5. Social Security Number 219–76–4779	6. Sex		7. Age (li	n yrs. last birtho	Months	r 1 Year	If Under 24	Hrs. 8 Min.	B. Date of Bir (Month, Da 5-13-	th ay, Yea 59			lace (State or Foreign
10		/land		Usual Residence of Decede 10a. State 10b. Co			10	Oc. City, Town o	r Location							1	Od. Inside City Limits
3		e Man Sa-f sh	ctor	Md.	NA			Balt	imore								X Yes 2 □ No
590		with th	Director	10e. Street and Number					10f. Zi	p Code 212	20			10g. C	Citizen of WI USA	at Coun	itry?
(3)		death ms 23	Funeral	829 W. Cro		12. Was Dec	edent Eve	r in U.S.	13. Was Dece			n? (Speci	ify Yes or No)-	14. Race	Americ	an Indian,
0	5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic svent, the Medical Examinar must be notified at once.	by	1 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Dive		Armed For 1 Yes If Yes, Given Year or D	2 K No		if Yes, spe 1 ☐ Yes		n, Mexican, F Specify:	Puerto Ri	can, etc.)		Specify:	White,	etc.
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	ē,	s 1 and Heal of Heal item 2		Tyrone Roger 20a. Method of Disposition			on 2	20b. Place of Di cemetery,	1 W. C			Dat	100		Location - C	212. ity or To	
	Ë	Page ment c ent: If ury or		1 ☐ Burial 2 ☑ Crema `4 ☐ Donation 5 ☐ Oth	ition 3 □R ier <i>(Specify)</i>	emoval from	State		mount			-30-0	04	Ba	ltimo	e, l	Mđ.
	Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Se	rvice Ließns	h pro-			22. Name a		s of Facility East	:	Bal 1101 E	tim . N	ore, N	ld. Ave.	21202
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		To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ledical Co	29a. Certifier 1 Cer (Check only 2 Mec	tifying Phys lical Examin	er: On the b	asis of exa	y knowledge, de mination and/o	eath occurred investigation	at the time	e, date and pi	lace, and	due to the o	cause(s	s) and mann	er as sta	ited. the cause(s)
	200	To this within To tha comple	Med	29b. Signature and title of ce	ertifier	and man	ner stated.		290	c. License	number			29d. Da	ate signed (/	Month, D	ay, Year)
				> M An	thm	Mile	3 mg)	E	25	205			Ap	ril =	24.	100 K
		10		30. Name and address of pe		mpleted caus	e of death	(Item 23a) (Typ	e, Print)	St. (Polts	. Ma					
		Sta Registr		31. Date filed (Month, Day,) APR 2			egistrar's	,	A.	.c. 21	,						

		1 - State Registrer 1. Decedent's Name (First, Middle,				rtment of H			eg. No.	4 1311
Physicia /Medica	al		Arn		As	kins		Month 4	Day Yea 17 2004	12 NOON
Examine	er	4a. Facility Name (If not institution, 5008 Gwynn Avenu 5. Social Security Number	1e	nber) 7. Age (In yrs. la		4b. City, Town, or Balto If Under 1 Year	Location of Deet		4c. County of De	
Funeral Director		217-14-0460 Usual Residence of Decedent	1 M 2 F	84	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 2 3	1920 9. E	Birthplece (State or Fore Country) Md
-f show	tor	10a. State 10b. County Md	N/A	10c. City Balt	, Town or Lo	cation				10d. Inside City Lim
ms 23e or 28e-f show	al Director	10e. Street and Number 5008 Gwynn Ave		Bull		10f. Zip Code 212	07	1	0g. Citizen of What	Country?
al', or ita	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	e	1	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, Wi Specify: B	
404	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)			(Give life. L	ent's Usual Occupa kind of work done d DO NOT use retired, cher Assi	luring most of wor)	king	16b. Kind of Busines	ss/Industry
aven sten	To Be Co	12th grade 17. Father's Name (First, Middle, L Josiah Wilson		113	Teat	Mer Assi	18. Mother's Nar	ne (First, Middle, M	Maiden Sumame)	
27 Is marr trauma	ř	19a. Informant's Name/Relationsh Olivia McFarl		ıghter			nd Number or Ru		City or Town, State	
nent of Hears ant: If Item		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.	3 Removal from	20b. Pla	ace of Dispos metery, cren	ition (Name of atory or other place	9)	Date	Arbutus,	or Town, State
Department of Important: If say injury or once.		21. Signature of Funeral Service L	John	end		Name and Addres	Maba	arch F/H sh Avenue	West Balto, N	(d. 21215
hysician /Medical xaminer	er	23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a. Due to (Schemor as a conseque or as a conseque	nce of):	1	myo po	ease	st,	Approximate Interval Between Onset and Death
physicials the bur	edical Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque	ence of):	Leosis	>			
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2 5	Completed							24a. Was an autopsy perform	prior to ed? death?	autopsy findings availa completion of cause of
풀끝	Certification: To Be	25. Was case referred to medical examiner? 1 M Yes 2 No 27. Manner of Death 1 M Natural 5 Pending investiga	28a. Date o (Month		P/Outpatient 28b. Time of Injury	3 DOA Other	r: 4 □ Nursing Ho	th (Check only one one 5 Resider 28d. Describe how	nce 6 Other (Sp	ecify)
urs after d ral Direct		3 Suicide 6 Could no 4 Homicide determin	buildin	of Injury - At hom ng, etc. (Specify)		•		City or Town,	,	,
hin 24 ho the Fune mpletely fi	Medical	one)	Physicien: To the xaminer: On the ba and mann	sis of examination	ledge, death on and/or inv	estigation, in my opi	nion, death occur	red at the time, da	use(s) and manner a te and place, and du	e to the cause(s)
To		29b. Signature and title of certifier	1				number +3 43	29	d. Date signed (Mon	th, Day, Year)
0-		30. Name and address of person w	ho completed cause	of death (Item 2	23a) (Type F	rint\				

DHMH 17 Rev 1/2001

ORIGINAL

RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of M	aryland / Depa <i>Ce</i> a	artment of I rtificate of			giene20	04 13115
Physicia /Medic		1. Decedent's Name (First, Middle, Las Junior F. Atki					2. Date of De Month APRIL		Year 04 20P.
Examin	er	4a. Facility Name (If not institution, give 524 N. Charles Str	eet		BALTIMO			4c. County	
Funeral Director		Social Security Number unk ₆ , Social Security Number 1 Usual Residence of Decedent	9X 7. Ag	78 Yrs.	If Under 1 Year Months Days			1925	Birthplace (State or Foreign Country) UNK
Maryland -f show	tor	10a. State 10b. County MD		10c. City, Town or Lo	ocation Baltimore	2			10d. Inside City Limits 1 X Yes 2 □ No
with the	i Direc	10e. Street and Number 524 N. Charles S	treat #916	5	10f. Zip Code	21201		10g. Citizen of W	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ARRE.	by Funeral Director	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hif Yes, specify Cub	Hispanic Origin? an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race	SA - American Indian, K, White, etc. white
ed within 72 hours afl ygjene. ar than "natural", or t, tre Medical Exarri	Completed			(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	vorking unk	16b. Kind of Bu	siness/Industry unl
ould be fill Mental Hy arked oth atic even	To Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's N	ame (First, Middle,	Maiden Sumame	unk
and 2 should be file ealth and Mental Hy m 27 is marked oth her traumatic event		19a. Informant's Name/Relationship (7	ype, Print)	11	1 Penn S		Rural Route Numbe altimore,	-	
Dermit. Pages 1 a Department of Hes Important: if item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🖾 Other (Specify	Removal from State) in state	1	sition (Name of natory or other pla	ce)	Date	20c. Location - (City or Town, State
permit. Departimport any inj		21. Signature of Funeral Service Licen. ROTA DI S	Wade tip	ector 22	Name and Addre tate Ana altimore	ss of Facility LOMY Boa	ard 655 W	. Baltim	ore Street
Physician // Medical Examiner business and business the prival transit sthe prival transit states and busines	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entler Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c	a consequence of): a consequence of):	iosclerot	ic Card	iovascula	r Diseas	se
death certifi e attending d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy	/		23d. Date Mont	of delivery th Day Year
igne bed	þ	Part II. Other significant conditions co	ntributing to death be	ut not resulting in the ur	nderlying cause giv	en in Part I.			oute to the cause of death?
. The law requires that the cate has been signed by the page 2 should be detache	Completed						24a. Was a autops perform	ned? pr	ere autopsy findings available for to completion of cause of ath? Yes 2 \(\) No
hysi this c	ation: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injur Wor	er: 4 🗌 Nursing	eath (Check only on Home 5 Reside 28d. Describe ho	ence 6XIOther	(Specify/SCENE
tal or Attend s after death al Diractor: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	rry - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number 1, State)	or Rural Route Number,
Hospi 4 hou Funer ely fill	edicai	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exami	sician: To the best of ner: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	occurred at the tin estigation, in my o	ne, date and place pinion, death occ	e, and due to the ca curred at the time, d	ause(s) and mani ate and place, an	ner as stated. d due to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier Josephan	hare	110	29c. Licens				(Month, Day, Year)
		30. Name and address of person who co	empleted cause of de	11				PRIL 18, e, Maryl	and 21201
Stat Registra	4 3	31. Date filed (Month, Day, Year) APR 2. 7.2		r's Signature	back of				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #26 PER VERB 0830 2/27/04 entificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5318 AN The 2004 72 4a. Facility Name (If not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard

If Under 1 Year | If Under 24 Hrs.

21043

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Ellicott City

10f. Zip Code

1 ☐ Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

7. Age (In yrs. last birthday)

62

10c. City, Town or Location

Funeral Director

Physician

/Medical

Examiner

5. Social Security Number

213-40-4359

10a. State

Maryland

10e. Street and Number

Usual Residence of Decedent

1 Never Married 2 Married

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

10b. County

Howard

3218 Wheaton Way Apt. B

15. Decedent's Education (Specify only highest grade completed)

6 Sex

10 M 2 F

12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 2 No

College (1-4or 5+)

notified at the s 23a or Completed by Funeral other treumatic event, the Medical Exeminer m ö "netural", Hygiene.

filed within 72 hours after 3altimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Itam 27 is marked other the any injury or other treumsting. Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leonard Mark Stevens Viola Catherine Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirk Bridygham/son 4941 Columbia Road Apt. E Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 □ Burial 2 ♣ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/24/04 21. Signature of Figeral Remove Town C McDonald ^{22. Name and Address of Facility}
Cremation Society of Maryland,
299 Frederick Road Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a fact line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner נכו מש מ בטוושבעם שוועם certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 the attending physician by Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant ō 3 ☐ Ectopic pregnancy in the past 12 months? signed by the at d be detached for P.O. 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 Yes Completed should peeu beson 24a. Was an has page 2 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 patient 2

28a. Date of Injury
(Month, Day Year) Other: 4 Nursing Home 5 PRESidence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this Director: After this in by the funeral d 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28c. Injury at Work? Certification: Division or Attanding 5 Pending Injury within 24 hours after death.

To the Funaral Director: A completely filled in by the fu investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Test Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signatore and title of certifier 29c. License number

10d. Inside City Limits 1 ☐ Yes 2 📉 No 10g. Citizen of What Country? USA 14. Race - American Indian Black, White, etc. Specify: White 16b. Kind of Business/Industry

Birthplace (State or Foreign Country)

Maryland

Domestic

8. Date of Birth (Month, Day, Year)

FEB 5.

1942

20c. Location - City or Town, State Baltimore, MD

Approximate Interval Between Onset and Death horr 23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

2 No 3 Probably 4 Unknown

Month

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 1 ☐ Yes 2 ☐ No

Day

Year

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

2004 ress of person who completed cause of death (Item 23a) (Type, Print) Colombia, MI)

ACKSEN j m) 31. Date filed (Month, Day, Year)

32. Registrar's Signature APR 2 7 2004

State Registrar

				State of Maryland / Department of Health an 1- State Registrar Certificate of Death	d Mental Hy	/giene 2 0	04 13117
		Physici		Dorothy M. Berger 1. Decedent's Name (First, Middle, Last) Dorothy M. Berger	2. Date of D Month		Year 3. Time of Death
		/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D NOTH Arundel Hospital 6100 Buch	eath	4c. County of	0
		Funeral Director		5. Social Security Number 216 18 7492 6. Sex 1 M 2 Sept 7. Age (In yrs. last birthday) 1 M Nonths Days Hours Nonths Days Nonths Days Nonths Days Nonths Days Nonths Nonths Days Nonths Da	Vin. (Month, D		Birthplace (State or Foreign Country) Maryland
		aryland ehow	2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Glen Burnie			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
7		ith the M or 28a-f	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of W	
2		be filed within 72 hours atter death with the Maryland lat Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funerai	216 Juniper Court 21060 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No 21060 13. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	? (Specify Yes or Nuerto Rican, etc.)	Black	- Americen Indian, c, White, etc.
othy	215-0036	2 hours at stural', or cal Exam	by	3 ∑XWidowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2X No Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation		Specify:	White siness/Industry
Doc	21215	- 3	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) 9th (Give kind of work done during most of life. DO NOT use retired) Self employed	working		nel Agency
2	Maryland	2 should be filed within and Mental Hygiene. is marked other than aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event, the Mental aurmatic event	To Be		Name (First, Middle Nary A. Ce)
96	Mary	s 1 and 2 should I f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of 112 Rabbit Hill Road)			State, Zip Code) ryland 21623
30	altimore,	ages 1 ar		20a. Method of Disposition 1 □ Partial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - 0	City or Town, State
-	Baltin	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Gonce Fur	neral Ser	on, Virginia Vice, P.A.
		42144		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.			Maryland 21225 Approximate Interval Between
		Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Onset and Death
		euted id ansit	Examiner	Sequentially list conditions, if any, Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	mg		
	,0928	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last Due to (or as a consequence of): d			
1/2	.O. Box 6	ne death certiff the attending hed for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Tho 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date Mon	of delivery th Day Year
	Ο.	quires that the signed by and be detacted		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Í	bute to the cause of death?
	Division of Vital Records,	The law requir rate has been si page 2 should	Completed		24a. Was auto perf 1 🗆 Yes	ppsy pr ormed? de	ere autopsy findings available ior to completion of cause of sath? Yes 25 No
	f Vita	ysician: The ils certiticate ha director, page	To Be	examiner? Hospital: /	Death (Check only		r (Specify)
	sion o	ending Ph eath. or: Atter th he funeral	Certification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe	how injury occurre	d
	Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	wn, State)	r or Rural Route Number,
		he Hosp in 24 hou he Funer pletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	lace, and due to the occurred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
)	To T To I	Σ	29b. Signature and title of certified 29c. License number D 4 80 0b		29d. Date signed	(Month, Day, Year) 21st, Zout
		8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Dr., 6	Im B	wnit, mD
	*	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Dorothy

0

Patricia Anne Bronson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Physicia /Medic	an	Decedent's Name (First, Middle, Last		Bronso	artment of H tificate of L		2. Date of Death Month March		3. Time of Death
Examin	_	4a. Facility Name (If not institution, give 908 Victory Lane	street and number)		4b. City, Town, or Brookly		h	4c. County of Deal	th
uneral irector		5. Social Security Number 6. Se unknown 1. Usuel Residence of Decedent	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Birt 1930 Ma	hplace (State or Fore junity) aryland
28a-f ehow		10a. State 10b. County Maryland Anne Ar		ity, Town or Lo			<u>-</u>		10d. Inside City Lim
23e or 26	۵	10e. Street and Number 908 Victory Aven	iue		10f. Zip Code 2122	5	10	g. Citizen of What Co	untry?
af, or items	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	Was Decedent of Hi f Yes, specify Cubar I ☐ Yes 22 No		pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
f other then "naturel", vent, the Medical Exc	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 10th	cation (e completed) College (1-4or 5+)		tent's Usual Occupa kind of work done d DO NOT use retired, punch Ope			Mercy Hos	,
marked other	To Be C	17. Father's Name (First, Middle, Last) Claude B				Jos	ne (First, Middle, Ma sephine Ro	aiden Sumame) OSS	
ther traum	3	19a. Informant's Name/Relationship (Ty Jean Basciano /	sister	6239	Medora Ro	ad		City or Town, State, Z n, Maryland	
int: if Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 점 Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Ba	Place of Dispo- cemetery, cren yview C	sition (Name of natory or other place rematory			oc. Location - City or Baltimore,	
Important: If any injury or once.		21. Signature of Funeral Service Licens		22		of Facility Go	once Funer	al Servic	e, P.A.
rsician ledical aminer	liner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Arterioscleroti a Inhalation Due to (or as a consec		vasoular Di	sease com	olicated by	snoke	Interval Betweer Onset and Death
	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.						
by the attending physicie lached for use as the bu	hysician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consect of the conse	ancy al death 3 death 5 death	Ectopic pregnancy Other (specify)			23d. Date of delin Month	Day Year
igned by the attending physicis	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a consect of the conse	ancy al death 3 death 5 death	Other (specify)	n in Part I.	1	Month	Day Year
as been signed by the attending physicit 2 should be detached for use as the bu	e Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect of the conse	ancy al death 3 death 5 death	Other (specify)		1 Yes 24a. Was an autopsy performe 1 Yes 2	Month coo use contribute to 2 No 3 Pro 24b. Were aut	Day Year the cause of death? bably 4 Unkno
rrector: After this certificate has been signed by the atlending physicit to by the funeral director, page 2 should be detached for use as the bu	To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	Due to (or as a consect of the conse	ancy al death 5 sulting in the un BER/Outpatient 28b. Time of Injury 8:47	Other (specify) derlying cause gives 3 DOA Other 28c. Injury Work?	26. Place of Dea - 4 ☐ Nursing H	24a. Was an autopsy ferforme 1 X Yes 2 th Check only one 28d. Describe how Victim of h	Month 20 use contribute to 2 No 3 Pro 24b. Were aut prior to codeath? No death? No death? No death? No death? See 6 Mother (Special injury occurred) 101 See fire	bay Year the cause of death? bably 4 □Unknot opsy findings availa ampletion of cause 2 □ No SCENE
rrector: After this certificate has been signed by the atlending physicit to by the funeral director, page 2 should be detached for use as the bu	Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions cond	Due to (or as a consect of the conse	ancy al death 3 death 5 death 6 death	Other (specify) derlying cause gives 3 DOA Other 28c. Injury Work? Ma 1 Ye et, factory, office	26. Place of Dea 4 □ Nursing H at as 2 ☑ No	24a. Was an autopsy derforme 1 X Yes 2 th Check only one 28d. Describe how Victim of 1 28f. Location (Stree City or Town, 5 28f. And due to the cause and due to the cause and due to the cause and due to the cause 24f.	Month 20 use contribute to 2 No 3 Pro 24b. Were aut prior to co death? 100 Se 6 Mother (Special injury occurred 201 Se fire stand Number or Run (State)	the cause of death? bably 4 Unknown opsy findings availation of cause of the cause
rel Director: After this certificate has been signed by the attending physicit lied in by the funeral director, page 2 should be detached for use as the but	ledical Certification; To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consect of the conse	ancy al death 3 death 5 death 6 death	Other (specify) derlying cause given 3 DOA Other 28c. Injury Work? M 1 Your et, factory, office occurred at the time estigation, in my opi	26. Place of Dea 4 \(\tag{Nursing H} \) at as 2 \(\tag{No} \) by date and place, nion, death occur	24a. Was an autopsy before the last of the	Month 20 use contribute to 2 No 3 Pro 24b. Were aut prior to co death? 100 Se 6 Mother (Special injury occurred 201 Se fire stand Number or Run (State)	bay Year the cause of death? bably 4 Unkno opsy findings availa ompletion of cause of 2 No fy) SCENE al Route Number, stated, o the cause(s) Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Ethel M. Bennett April 18 2004 12:50 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Villa Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 ▼ F Yrs Director 212-20-7831 97 \$ept. 2,1906 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore <u>Catonsville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Enjay Ave. U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 □Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify ģ Specify: 3 ₩ Widowed 4 Divorced "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Itam 27 is marked other tt any injury or other traumatic event, ITA 2002. 5 Umbrella Manufacturer Umbrella Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Smith Elizabeth Pardoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Bennett, Grandson 108 Melvin Ave. Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 4-22-2004 Elkridge, Maryland 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Euneral Service Licensee Tepen & 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Skeletal Metastasis Weeks resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (ur as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760 Physician/Medical as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Senility Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has s certificate has lirector, page 2 or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only of Hospital: 1 Inpatient 2)(1 No ို 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Centr 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury s after death. 1 ☐ Yes 2 ☐ No in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 1.5 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certified 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIDENCHOICK Come Balfin ONEL 1101 - 8-31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 7 2004 Registrar

	1 - For State Registrer	State of Maryland / L	Department of Health and Certificate of Death		ene 2004	1312
Physician	1. Decedent's Name (First, Middle, Last)	Bezil		2. Date of Death		3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give str	reet and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	110
Funeral Director		7. Age (In yrs. last bin	hday) If Under 1 Year If Under 24 Hr. Months Days Hours Min	(Month, Day,	Year) 9. Birthy 1901 Jama	place (State or Forei ntry) ICa, BWI
f show	Usual Residence of Decedent 10a. State 10b. County MD Carre	10c. City, Town	or Location Sykesville			10d. Inside City Lim
a or 28a-f si be rotified Director	10e. Street and Number		10f. Zip Code	10	Og. Citizen of What Cou	ntry?
ital Hygiene. od other than "natural", or items 23a or 28a-f show evant, the Medical Exeminer must be routiled at Be Completed by Funeral Director	710 Obrecht Road 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	t. Was Decedent Ever in U.S. Armed Forces? 1 _ Yes 2 _ XNo If Yes, Give X Year or Dates:	21784 13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	USA 14. Race - Americ Black, White, Specify: WI	
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is certificate has been s director, page 2 should To Be Completed				24a. Was an autopsy performe	24b. Were auto prior to con death? No 1 \(\text{Yes} \)	psy findings availab mpletion of cause o 2 No
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within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Medical Certification; 7	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa. building, etc. (Specify)		City or Town,		
thin 24 hours the Fune impletely fil	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Exemine	r: On the best of my knowledge r: On the basis of examination and and manner stated.	, death occurred at the time, date and plac d'or investigation, in my opinion, death occ	urred at the time, date	te and place, and due to	the cause(s)
To To Marith	29b. Signature and title of certifier	fim (yellin	29c. License number 600059443	290	d. Date signed (Month,	Day, Year)
11	30. Name and address of person who com	pleted cause of death (Item 23a) (Type, Print)			

			1 - State Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of F	lealth and Death		giene 200	4 13121
19	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) PATRICIA	ANN B	ANO	ELL		2. Date of Dea Month APA L	Day Year	MSCPIP
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	ith the Mar or 28a-f al	Director	Maryland N/A 10e. Street and Number		Ltimore	10f. Zip Code		1	l0g. Citizen of What C	XX Yes 2 □ No country?
9036	be filed within 72 hours after death with the Maryland hal hygiene. Id thygiene. Id other than "natural", or Itema 23a or 28a-f ahow avent, the Medical Examinar must be notified at	by Funeral Director	3401 Pleasant Place 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed ★☆ Divorced	Was Decedent Ever in U.S Armed Forces? 1Yes 2No If Yes, Give Year or Dates:	If	/as Decedent of H	211 dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	USA 14. Race - Am Black, Wh Specify: W	
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other t		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	oval from State Ba T	timore Crema	atory or other place -Washing tory Name and Addre	ss of Facility	7/2004	Laurel, Ma	aryland
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)	To To con	Σ	29b. Signature and title of certifier	an l	47	29c. License	733	3 /	d. Date signed (Mont FRIL 2	h, Day, Year) 2 , 200 y
	0		30. Name and address of person who comp	MO, NHC	_31	TL 70	MO 2	1133		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 2004	32. Registrar's Signatu	JI G	South	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 2000

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	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Thuddeus R.		nes	April 2	Day Year 2004	3. Time of Death 7:46 A M
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	Funeral Director			Age (In yrs. last birthday, 48 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye		place (State or Foreign Wroling
	tryland thow	_	10a. State 10b. County	10c. City, Town or Lo			1	Od. Inside City Limits
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Example must be notified at ance.	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Give	ident's Usual Occupation is kind of work done during most of work DO NOT use retired) STOQUOM	ing 16b.	Kind of Business/Inc	fustry
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	ne Hospital on 24 hours af ne Funeral Dietely filled in	aj Cel	29a. Certifier 1 ☐ Certifying Physician: To the be	est of my knowledge, death	n occurred at the time, date and place, a	and due to the cause	s) and manner as eta	Maily (a, of
	To the Ho within 24 h To the Fu completely	Medical	(Check only one) Medical Examiner: On the basi and manner 29b. Signature and title of certifier	s of examination and/or inv	vestigation, in my opinion, death occurre	ed at the time, date a	nd place, and due to t	the cause(s)
	5 W T 0		Thead. II les		29c. License number O.C.M.E.		il 21, 200	
	2		30. Name and address of person who completed cather theodore King M.D.			_		
8	Sta	te.		istrar's Signature	a de	Lemore, P	myrual 2.	LEUI

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Baltimore,	t. Pages 1 treent of H tant: If ital		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐Removal from State	cemetery,		04/2	.8/04 Ra		in, State
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3	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Preumot	thor	enter the mode of dyir	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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P.O. Box 68760,	Attending Physician: The law requires that the death certificate be executed or death. •ctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	nancy tal death	3 Ectopic pregnance	,		23d. Date of delir Month	very Day Year
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Vita	slcian: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Malpatient 2	⊒ ER/Outpa	itient 3 DOA Oth	or	h (Check only one)	C DOther (Cons	
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ORIGINAL

		1 - For Un pend ITem#23 Registrar 1. Decedent's Name (First, Middle, Las.						2. Date of Deat	7		3. Time of Death
Physici /Medic		Marvin Bro	wn					Month APRIL	8, 200	Year)4	2:23 P M
Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City	y, Town, or	Location of De	ath	4c. County		
		1701 EUTAW PLACE				LTIMO	ORE CIT				
Funeral Director			M 2□F	53	Yrs. Months		Hours M		^{Year)} 1953	9. Birthpla Country	ce (State or Foreign y) unk
N H	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location					100	d. Inside City Limits
in the second	ğ	MD		Ва	ltimore						1 Yes 2 □ No
ms 23a or 28a-f show	Director	10e. Street and Number			10f. Z	ip Code	<u></u>	10	g. Citizen of V	What Countr	y?
23a	rai	1701 Eutaw Place					21217			JSA	
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-fehov any injury or other traumatic event, the Medical Examiner must be rollified at any injury or other traumatic.	by Funerai	11. Marital Status UNK 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	1	k 13. Was Dec If Yes, sp 1 Yes		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		e - Americar ck, White, et b1a	c.
natur	eted	15. Decedent's Edi	cation e completed)	16	a. Decedent's Us		ation furing most of v	vorking unk	6b. Kind of Bu	ısiness/Indu	stry unk
Mes	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT	use retired)				
hert H		unk 17. Father's Name (First, Middle, Last)	nk			1	19 Motharia h	lame (First, Middle, M	laiden Sumam	101	
arked of	To Be					unk					unk
7 is m traum		19a. Informant's Name/Relationship (T) O.C.M.E.	rpe, Print)					Rural Route Number, imore, MD	City or Town, 21201	State, Zip C	code)
tem 2 other		20a. Method of Disposition		20b. Place	of Disposition (Na	ame of	1		Oc. Location -	City or Tow	n, State
nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 🛣 Other (Specify,			ery, crematory or	otner plac	θ) : !				
eny inju		21. Sphature of hyneral Service Licent	ade, Dire	ector	State Baltin			rd 655 W.	Baltimo	ore St	reet
sician edical miner		23a. Park. Enter the dise Fe, or Sont shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Liver Ci Due to (or as	10.		ode of dying	g, such as card	iac or respiratory arre	st,	10	Approximate Interval Between Onset and Death
for use as the burial-transit	Icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o	a consequence							
detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal deat	th 3 ⊟Ectopic 5 ☐ Other (s				23d. Date Mor	e of delivery	ay Year
ည် ရှိ	by	Part II. Other significant conditions co	ntributing to death bu	ut not resulting	in the underlying	cause give	en in Part I.				cause of death?
After this certificate has been s funeral director, page 2 should	Completed							24a. Was ar autopsy perform 124 Yes 2	р	rior to comp leath?	y findings available pletion of cause of
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	10	eath (Check only one			ATL COTTAGE
r this	. To	1 X Yes 2 No 27. Manner of Death	1 Unpatie		Outpatient 3 C	JUA	4 🔲 Nursing	Home 5 Resider		* * * * * * * * * * * * * * * * * * * *	AT SCENE
tor:	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injur (Month, Day 28e. Place of Inju	ury - At home, t	Injury M		(? Yes 2 □ No	28f. Location (Str	eet and Numbe		Route Number,
To the Funeral Director: completely filled in by the		4 Hornicide	building, etc		no doub ansure	el a è è la a è la e		City or Town,			
To the Funeral Direc completely filled in by	Medical	(Check only one) 2 Medical Exam	ner: On the basis of and manner sta	examination a	ind/or investigation	n, in my op	pinion, death oc	curred at the time, da	te and place, a	and due to th	ne cause(s)
comp	Me	29b. Signature and title of certifier	eed A	19	29	9c. License	number C.M.E	29	d. Date signed APRIL	(Month, Da 9, 2	2004
			- 41								

Division of Vital Records, P.O. Box 68760,

			1 - State of Maryland / Department Certification	nt of Health and M Te of Death	ental Hygien Reg. N	
	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month D	3. Time of Death
	Physici /Medio		Leroy Barnes		April 05,	, 2004 0033 A M
	Examir	er		Town, or Location of Death	4	c. County of Death
	Funeral Director			timore r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year May 15, I	9. Birthplace (State or Foreign Country) Maryland
	pur *		Usual Residence of Decedent 10a. Stateunk 10b. County unk 10c. City, Town or Location			10d. Inside City Limits
	se Maryli Ba-f aho	Director				unk unk ^{1 Yes} ^{2 No}
	th with the 23a or 28		10e. Street and Number unk 10f. Zi	o Code	unk 10g. C	itizen of What Country? USA
920	d within 72 hours after death with the Maryland Jiene. I than "natural", or Itema 23a or 28a-f ahow The Medical Examirar must be notified at	by Funeral	11. Marital Status Y 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes 3 ive Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes 3 ive Year or Dates:	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto for 2012). No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: black
Maryland 21215-0036		Completed	life DO NOT I	ork done during most of working	16b. 1	Kind of Buşiness/Industry
212	e filed within II Hygiene. other than "	omo	Elementary/Secondary (0-12) College (1-4or 5+)	Laborer		city of Baltimore
nd	0 12 O a	Be	17. Father's Name (First, Middle, Last) George Kane		(First, Middle, Maide	•
ryla		ို		Myrt S (Street and Number or Rura	le Wheatle	
	nd 2 state and 2 state and 27 is r trau			ridge Road Gl		
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) in State	me of Di other place)	ate 20c. l	Location - City or Town, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signatur of Funeral Service Licensee Ronal S Ward Director State Baltim	nd Address of Facility Anatomy Board Ore, MD 21201	655 W. Ba	ltimore Street
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. [Hypertensive afterwork] Due to (or as a consequence of):	pretic cardiova	senter die	Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):			
5	xecuter and al-transi	Examiner	Cause (Disease or injury that initiated events c			
68760	icate be executed physicien and s the burial-transit	dicai	d			
.O. Box	death certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death			23d. Date of delivery Month Day Year
rds, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
I Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? o VAYes 2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		
of		: To	1 Inpatient 2x 12HVOutpatient 3 D		ne 5 Residence 8d. Describe how inju	ury occurred
ion	Attending F r death. ector: After by the funer	atior	1 □Natural 5 □ Pending (Month, Day Year) Injury I 2 ■ Accident investigation Found 4/9/by Found 4/by M	Work? 1 ☐ Yes 2 No D	stated exp	isfeel to cold westler
Division	of or Attence after death Director: d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)		City or Town, Stat	nd Number or Rural Route Number, te) ((Stree, Battimure 1841)
	To the Hospital or within 24 hours after To the Funeral Direcompletely filled in L	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred 2 Medicel Exeminar: On the basis of examination and/or investigation and manner stated.	at the time, date and place, a	nd due to the cause(s	s) and manner as stated.
	To the within To the comple	Me	29b. Signature and title of certifier 29	c. License number	29d. Da	ate signed (Month, Day, Year)
				O.C.M.E.	Ap	ril 05, 2004
				nn Street, Ba	Ltimore, M	aryland 21201
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 2004	west.		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 State
Registra/MEND ITEM #26 PER VERB C830 4/27/04Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2004 2048M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb Town, or Location of Death **Examiner** pita 5 od Saman more If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day. 5. Social Security Number 6. Sex s. last birthday) **Funeral** Director Usual Residence of Decedent Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Exertines must be notified at ACTIMORE 1 Yes 2 No Directo 10g. Citizen of What Country? Funeral 14. Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 1 Never Married 2 Married ō 2 No Baltimore, Maryland 21215-0036 1 Tes þ 3 Widowed 4 Divorced Year or Dates "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then eny injury or other trainmain. Elementary/Secondary (0-12) College (1-4or 5+) :00K 18. Mother's Name (First, Middle, Maiden Sumame) er's Name (First, Middle, Be VICTORIA 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) MVE. APT 20a. Method of Disposition BALTIMORE, MARYLAND 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4.23.04 4 ☐ Donation 5 ☐ Other (Specify) HN C. GREENE FUNERAL HOME 21. Signature of Funeral Service Licensee brech 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PSIS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No po Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Cell 2 No 3 Probably 4 Unknown 1 Yes Trackerston 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Gastrotum Tube 2 No 1☐ Yes 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence O Dother (Se 1 Yes 2 No Medical Certification; To 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10058570 4-18-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Sanaritan Hospith, Baltimore Baken errance 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edward L. Collison Sr. State of Maryland / Department of Health and Mental Hygiene 2001 04 - 27451 - For Stata Registrar Certificate of Death **AKG** Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2:56 A April 2 2004 Edward Leroy Collison, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/AUniversity Hospital If Under 1 Year | If Under 24 Hrs. Wonths | Days | Hours | Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1**∑**M 2□F Months Yrs. 66 20, 1938 Director Feb. Maryland 219-26-6224 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 217 Kuethe Road Unites States 21060 Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'neturel', or 1 ☐ Yes 21 No Specify: Specify: White 3 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Transportation filed 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other traumatic avent 17. Father's Name (First, Middle, Last) Be Holly Bernard Collison Margaret Mary Donlan ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward L. Collison, Jr. 3809 Main Street, Grasonville, MD 21638 20b. Place of Disposition (Name of comptery, crematory or other place)
Meadowridge Memorial 20c. Location - City or Town, State 20a. Method of Disposition

Burial 2 □ Cremation 3 □ Removal from State 4 Qonation 5 Other (Specify) 4-26-2004 Elkridge, MD Park 21. Signal P(Funeral Service 22. Name and Address of FacilityAmbrose Funeral Home , Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 as 2 No 24a. Was an autopsy performed? 1 Yes 2 □ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To XXYes 2 □ No XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

nerel Director: After this filled in by the funeral di 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: Natural 5 Pending investigation 2 🗆 No 1 🗆 Yes 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a

To the Funerel C

completely filled t 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier LAA April 22, 2004 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD ANA 111 Penn Street, Baltimore, Maryland 21201 36. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 7 2004 Registrar

unnend item#23a,27,PER ME,C832,6/8/04eg

			1 - For State Registrar	State of Maryland	/ Depa	irtment of He tificate of E	ealth and M Death	lental Hygie	2004	13128
歌が	Physic		1. Decedent's Name (First, Middle, Last) Patricia	Ann	Calle	etto		2. Date of Death Month April 23	Day Year	3. Time of Death 9:50 A
	/Medi Examir		4a. Facility Name (If not institution, give standard Arundel Medica 5. Social Security Number 6. Sex		t birthday)	4b. City, Town, or I Annapol: If Under 1 Year	is	8. Date of Birth	4c. County of Death Anne Arui	ndel
	Funeral Director			M 2X)F 63	Yrs.	Months Days	Hours Min.	(Month, Day, Ye	1940 New	place (State or Foreign http) York
	ne Marylan Ba-f show	Director	Maryland Prince Ge	orges Bow		cation			1	0d. Inside City Limits 1 Yes 2 No
	th with the	al Dire	10e. Street and Number 15221 Noble Wood L	ane		10f. Zip Code 20716			Citizen of What Cour	ntry?
936	urs after dea al', or items	by Funeral	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes ZYNo If Yes, Give Year or Dates:	l1	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No-	14. Race - Americ Bfack, White, Specify: White	etc.
1215-0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event. It a Medical Exertiner must be notified at	Completed	(Specify only highest grade	College (1-4or 5+)	(Give :	ent's Usuaf Occupat kind of work done du DO NOT use retired)	aring most of workin	ng 16b	Educatio	ŕ
Maryland 21215-0036	ould be fited Mental Hygi arked other atic event.	To Be Co	17. Father's Name (First, Middle, Last) Samuel J.	Calletto			18. Mother's Name Mary		den Sumame) ratassio	
2	1 and 2 sho Health and Iam 27 is m other treum		19a. Informant's Name/Relationship (Typ Thomas Calletto/ Br 20a. Method of Disposition	other 1	46 S.	Main Str	eet, Bat	avia, New	ty or Town, State, Zip York 140 Location - City or To)20
	permit. Pages 1 and 2 should Department of Heath and Men Important: If item 27 is marke any injury or other traumatic. <u>once</u> .		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeraf Service Licensee	Sout	h Cem	sition (Name of latory or other place, letery Name and Address	5/4/	2004 Re	d Creek. N vans Funer	lew York
iii	Per In Per		23a. Part1. Enter the disease, or complic	ations that caused the death.	16	000 Annap	olis Roa	d, Bowie,	Maryland	20715 Approximate
	Physician /Medical Examiner	iner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Final Indextyns	Due to (or as a consequent	•					Interval Between Onset and Death
,8760,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	nce of):					
O. Box 6	I ne law requires that the death certification has been signed by the attending places 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
ords, P	w requires that been signed b should be det	by	Part II. Other significant conditions conti	ibuting to death but not resultin	ng in the un	derlying cause given	in Part I.	23e. Did tobacc	co use contribute to the	
		Completed	05 W					24a. Was an autopsy performed	prior to condeath?	osy findings available inpletion of cause of
Division of Vit	ing Pnys h. After this funeral dir	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death Natural 5 Pending investigation		/Outpatient b. Time of fnjury	3 DOA Other 28c. Injury a Work?	4 Nursing Hon		6 □Other (Specify, nitry occurred)
DIVIS	ital or Attano	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office	2	8f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
;	no the Hospital or within 24 hours afte To the Funeral Dis completely filled in	Medical	29a. Certifier (Check only one) 1	cian: To the best of my knowler: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time estigation, in my opin 29c. License r	nion, death occurre	d at the time, date a	e(s) and manner as sta and place, and due to Date signed (Month, D	the cause(s)
	S I O		· day	MD		Ds	-518	7	1/23/) Y
			Amery	pleted cause of death (Item 23	_	A A	1.	Med	ical Co.	nter
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 2004	32/Registrar's Signature	5	aparks				

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 200 **Physician** CORSEY John /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Colling Ver 100 10km 8 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer, Sept. 26, 1 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Deys Min. 1₩ 2□ F Hours 578-18-9909 82 Washington, DC Director Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland nent of Health and Mentel Hygiene. Int: If Item 27 is marked other than "natural; or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland Anne Arundel Crofton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1466 Crofton Parkway 21114 U.S.A. Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1.0.4.2.../ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White þ Year or Dates: 1943-45 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Safeway Foods 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Frank Joseph Copsey Mamie Powell ဥ 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Thomas Copsey/ Son 1466 Crofton Parkway, Crofton, Maryland 21114 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕅 Burial 2 ☐ Cremetion 3 ☐ Removal from State ö Depertment of Important: If any injury or Maryland Veterans 4/30/04 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner for use es the burief-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the ungerlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? by 1 Yes 24 No 3 Probably 4 Unknown Be Completed by Hospital or Attending Physician: The law required 124 hours efter death.
 Funeral Director: After this certificate has been signed in by the funeral director, page 2 should the funeral director, page 2 should the funeral director. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed' 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred 1- Naturel 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of deeth (Item 23e) (Type, Print) Name end eddress 6a2 20 10805 32. Registrer's Signature

DHMH 16 Rev 6/95

State

Registrar

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND ITEM #25 PER PHY C830 2/27/04 Gentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day 25, Caffee, 2004 Felton April 12:45 A^M Jacob JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1XXM 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Yrs. June 28, Director 224-50-6897 65 1938 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinant mast technolished at 1 Yes 2 No Dunkirk Directo Maryland Calvert 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 12150 Dunleigh Court 20754 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 GYes 2 □ No If Yes, Give Year or Dates: 1961–65 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 Black 1 Tes 2 No à Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. Postal Services permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; If item 27 is marked othin any liquy or other traumatic event 2008; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jacob Felton Caffee Rosa Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Caffee/ Wife 12150 Dunleigh Court, Dunkirk, Maryland 20754 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Huntt Crematory 4/27/2004 Waldorf, Maryland * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached for o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, Meman 9 1 Yes 2 No 3 Probably 4 Dinknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 212 No Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XXVo Certification: To this iaral Diractor; After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1: Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funaral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State Registra

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien () 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 22 7:33 P ^M April Crook, 2004 /Medical Davis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 508 Luther Road Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) Mar 12, 1921 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Sex 14☐M 2☐F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 83 Yrs Director 263-24-8019 Florida Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Maryland Directo Anne Arundel Glen Burnie 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 Luther Road 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married Married X Yes 2 □ No 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 1950 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. Surveyor Engineering ges 1 and 2 should be filed at of Health and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Leroy Crook Myrtle Martha Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Edith Crook / wife 508 Luther Road Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) April 27, 20a. Method of Disposition 20c. Location - City or Town, State Important: If is any injure 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterens Cem. Crownsville, Maryland 2004 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home, P.A. Tark 1 Second Ave. SW, Glen Burnie, MD 21061 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physicien and thed for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not/resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 148 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate 1□ Yes 2 No INZOUSY 25/Was case referred to medical examiner? Physician: Be 26. Place of Death (Check only one) Hospital: P 1 ☐ Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 **(2)**Natural 5 Pending Injury 24 hours after death. • Funeral Director: A 2 No 1 Yes 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) ne and add 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004

								Cer	tificate	e of	Death		,	Reg. No		U4	13	132
	Diam'r.		1. Decedent's Name (First	Middle, L	est)								2. Date of De Month	eath Da	v	Year	3. Time of	Death
Į.	Physicia /Medic		Lora Vee Co	11ins	3								4	21		004	3:14	AM
)	Examine		4a Facility Name (If not ins	titution, gi	ve street and nu	imber)					4b. City, To	wn, or Lo	cation of Deet	th 4c	. County	of Death		
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	Funeral		5. Social Security Number		Sex 1 □ M 2 🗓 F	7. Age (la 43	n yrs. lest bi		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di	rth a <i>y, Yeer)</i>		9. Birthpl Count	ace (State o	r Foreign
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	288-	8	10e. Street and Number						10f. Zip	Code				10g. Cit	izen of V	What Count	trv?	
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	itar death with the Marylen thems 23st or 28s-f show liner must be notified at	era	11. Marital Status	anc	12. Was Dec	edent Eve	r in U,S.	13. V	1		lispanic Ori	igin? (Spi	ecify Yes or No Rican, etc.)			e - America	an Indian,	
20	filed within 72 hours after death with the Maryland Hygiene. ther than "ratural; or frems 23a or 28a-f show int, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2[3 Widowed 4 Dir		Armed For 1 ☐ Yes If Yes, Gi	2∭ No ive					an, Mexicar Specify:		Rican, etc.)			ok, White, e v: Whit		
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an	D = 0	Be	Donald K. T										. Kett1			,		
<u>=</u>	d 2 should th end Mer 7 is marke traumatic	9	19a. Informant's Name/Re	-			198	. Mailin	g Address	(Street			al Route Numb			State Zin	Code)	
S	17 F d	- 1	Mr. Donald T			er							asadena	-				1
ē,	s 1 and 2 of Health e ftem 27 is	-	20a. Method of Disposition	<u>uy 101</u>	, , , , ,		20b. Place o					I	Date	_		City or Tov	vn, State	
Baltimore, Maryland 21215-0020	permit. Peges 1 ar Department of Hea Important: If Item 2 any injury or other price.		MD Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot			State	Glen H	lavei	n Mem	ori	al Par	ck 2				nie,		
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}	Physician /Medical Examiner	ner	23a. P. 1. En er the dis- sinck, or heart failur Immediate Cause (Final disease or condition resulting in death)		a. OL	1601		DRI	062								Onset and E	
Box 68760,	rtificate be ng physicia es the bur	Medic	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· {	c		o to (or as a	,	,									
œ.	daath e atte d for		Part II. Other significant co	nditions (contributing to d	eath hut no	ot resulting i	n the un	derlying ca	ause div	en in Part I		23h. Did	tobacco	USA COR	stribute to	the cause o	f death?
P.O.	by the	Physician					-, , o, , , , , , , , , , , , , , , ,	., .,,,	30m, mg -	g					No		ably 4 □ 6	
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cord		Completed							_				24a. Was perfo	an autor ormed?	osy	ava con	re autopsy fi ilable prior to apletion of ca eath?)
æ	w T m	E											10	Von of	XINO .		Yes 2□	No.
ta	ician: The certificata rector, pag		25. Was case referred to m	edical							26 Place	of Death	(Check only					
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o uc	ing Phys		27. Manner of Death 1 Natural 5 □ !	Pending nvestigation	28a. Date (Mon		28b.	Time of njury		Bc. Injui Wor		1	28d. Describe			. ,	,	- 13
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ 0	Could not a determined	28e. Place	of Injury - ing, etc. (S	At home, fa Specify)	ırm, stre					28f. Location (City or To			er o <i>r Rurel</i>	Route Numi	ber,
	24 hours Funeral etely filled	edical C	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Pi dical Exa	nysician: To the miner: On the b	best of mag	amination an	o, death d/or inve	occurred a estigation,	t the tir	me, date en ppinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and mai	nner as sta and due to	ited. the cause(s)	
	To the Ho within 24 I To the Fu completel	_	29b. Signature and title of o	ertifier /	I				29c.	Licens	e number			29d. Dat	te signed	(Month, D	ay, Year)	
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	1_		30. Name and address of p	erson who	completed caus	a of doath	(Item 23e)	(Type P	Print)	16	200	>		()		UT		
	V		STUART GR	25514	ANMY) J	OHNS	Hol.	KINS	CAN	WER	Cen	ו אצה ן	BACT	MUR	EL	(1)	
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State of Maryland / Department of Health and Mental Hygien () () For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3:53 PM **Physician** 4006 Apri /Medical 4c. County of Death (If not institution, give street and number) Examiner aca St. 213 Baltimore If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State gr Foreign 5. Social Security Number 2/6-96 - 798 6. Sex 7. Age (In vrs. last birthday) Funeral 10 M 2 F Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or items 23a or 28a-f ahow Exerciner must be notified at Baltimore 1 Pres 2 No NIA Funeral Director 10g. Citizen of What Country? 10f. Zip Code USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Black 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working the DO NOT use retired)

NO - LOOK condary (0-12) College (1-4or 5+) Hygiene. n and Mental Hygien (First, Middle, Last) Mother's Name (First, Middle, Be ouise 2 Pages 1 and 2 should Name/Relationship (Type, Print) 19b. Mailing Address (Stre MD QIZIT permit. Pages 1 and 2::
Department of Health at Important: If item 27 is any injury or other trau balto. Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Gremation 3 Removal from State 5 Other (Specify) neral Scarce Licenses 21. Signature of 23a. Party Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia cuse (Final disease or condition resulting in death) **Physician** AIDS /Medical Due to (or as a consequence of) **Examiner** DIABETES MECUITUS Sequentially list conditions, if any, leading to immediate cause. Litter or Jerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760 attending physicien Iclan/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 0 Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the detached 9 Unknown 9 🗆 Unknown þ n signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No plnods Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 No 1 ☐ Yes 2 1 🔲 Yes of Vital 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one Hospital: Other: ome 5 sesidence 6 Other (Specify)
28d. Describe how injury occurred 2 100 2 ER/Outpatient 0 1 Tes 1 Inpatient 3 DOA 4 Nursing Home this in by the funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Aftert Certification; Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funerel Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 0 filled Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated the th 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/26/4 D58463 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST aki 1001 CATHEDRAC MD 32. Registrar's Signature 31. Date filed (Month, Day, Year, State NEAT 27 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 13 | 34 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month CHAMBERS 1:10 AM ANNETTE APRIL 2004 V. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HEALTHCHRE BALTIMURE CITY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2ÌXF 228-45-8550 **Director** MARCH 13 1924 JAMAICA Usual Residence of Decedent 10a. State 10c. City, Town or Location worke 10d. Inside City Limits item 27 is marked other than "natural", or Iteme 23a or 28a-f shov other traumatic event, the Nedical Examinat must be notified at 1 Yes 2 No Director MO BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31244 GALLOPING CIRCLE U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after ☐Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. CLOTHING SEAMSTRESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages 1 and 2 should be fill partment of Health and Mental H portant: If item 27 is marked ott y injury or other traumatic even RICHARD RUACHE FLORENCE MORGAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7917 GALLOPING CIRCLE BALTIMORE MA 19a, Informant's Name/Relationship (Type, Print) BRYAN KEITH Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
HCLY TRINITY RUSSIAN APRIL 29, at ELK RIDGE. MO 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or *4 □Donation 5 □Other (Specify) 21. Signature of Jun ral S, vice License 22. Name and Address of Facility THOMAS J. SKARDA F. H. 2829 HUDSON STREET BALTIMORE MO 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate U use (Final disease er ondition resulting in death) **Physician** 1SCHEMIC CARDIOMYOPATHY YEARS /Medical Due to (or as a consequence of): Examiner monTHS RENAL FAILURE THRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician sthe burial 68760 Physician/Medical Se attending Box IF FEMALE esn. 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 5 Other (specify) the a O 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be. 2 Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Yo 24a. Was an has autopsy perform page certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death, To the Funeral Director: After their completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the comp 27. Manner of Death 28b Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pendina investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P-15632 APRIL 26 30. Name and address of eyen who completed cause of death (Item 23a) (Type, Print) ANAKWA, 900 CATON AUE, BALTIMORE CYCLOPEA MD, 21229 31. Date filed (Month, Day, Year) APR 2 7 2004 32. Registrar's Signature State Registrar

III

HAMBER

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 6.54 PM Richard Cherry APRIL 73 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Honder 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 4 — 17 — 1951 SAMARITAM HOSPITAL G000 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral ™** M 2□ F 53 212-56-5949 **Director** Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Itema 23a or 28e-f show vant, the Medical Examinar must be notified at MD 1 Yes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2933 Guilford Ave. 21218 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Black þ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dept. of Water Elementary/Secondary (0.12) 12College (1-4or 5+) Balto. City Employee Works permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be James Cherry Annie Wicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2728 Guildford Ave. F Annie Wicks (mother) Baltimore MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Meadowridge Cem. 4-27-2004 Elkridge MD 21. Signature of Funeral Service Licensee

E.N. Walker Jr

22. Name and Address of Facility
Estep Bros. Funeral Service P.A.
1300 Eutaw PI. Balto. MD 21217

23a. Pert1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SERSIS **Physician** DEVERE /Medical Due to (or as a consequence of): Examiner EMBOCARDITIS Sequentially list conditions, if any, leading to immediate the leading to immediate the leading to immediate the leading to the leading that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-fransit The law requires that the death certificate be execufed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) has been signed by the great should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by KIDHEY 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No HROMBOCYTOPENIA 28 No certificate 1 ☐ Yes 2 X No the Hospitel or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☑ No this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending hours after death. unaral Diractor; Al 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide within 24 hours after To the Funeral Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HENLY ON after AM RES 000 2004 APRIL 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYONATOR RAVEH BOULEVARD 21239 5301 LOCH BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 27 2004

RICHARD

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 6:15 P.M JAMES EDWARD CENTINEO APRIL 20 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Yrs. Director 215-30-7233 15, 1933 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show ral, or items 23s or 28e-f show Exercises must be notified at 1 ☐ Yes 2X No Maryland Harford Bel Air Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1308 Gates Head Drive 21014 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: δ Specify: 3 ☐ Widowed 4 ☑ Divorced natural White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Pit Boss Gambling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nicholas James Centineo Cecilia Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i John B. Centineo - Brother 1308 Gates Head Drive, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Harford Mem. Gardens 4/23/04 Aberdeen, Maryland 21. Signature of uneral service Licen Ge 22. Name and Address of Facility McComas Funeral Home, P.A. March 11-mg 50 West Broadway Street, Bel Air, Maryland 21014 when that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** erepro Vascu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physician and the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending pl for use as t 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the aid be detached for 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 Yes 2 No 3 Probably 4 Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an 1□ Yes 2000 Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩o Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 8 Law Street Aberdeen, Mary hal d cause of death (Item 23a) (Type, Print) anue 31. Date filed (Month, Day, Year) APR 2 7 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 7:05P PM SARAH COLLIDGE APRIL 24, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 7 SLADE AVE. PIKESVILLE APT. #213 BALTIMORE Under 1 You Days Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV.11,1917 5. Social Security Number 6. Sex **Funeral** Months Hours 1□ M 2 F 216-46-5233 86 Director MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show ral', or items 23a or 28e-f show 1 ☐ Yes 2 ☐ No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural, or items 23a may injury or other traumatic event, the Medical Examinations." 7 SLADE AVENUE #213 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ WHITE 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) 12 HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS KAPLAN 2 HINDA KRAKAPOLSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 175 RIVERSIDE DRIVE - NEW YORK, NY 10024 KAREN CAPELLUTO / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WORKMEN CIRCLE CEM. 4/26/2004 * 4 ☐ Donation 5 ☐ Other (Specify) DUNDALK, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. scatt, 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician STA TA TIC /Medical Due to (or as a consequence of) Examiner squantinty list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has page 2 autopsy performed? Yes 25 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 2 1 ☐ Yes ≥ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 30. Name and address of person who could leted cause of death (Item 23a) (Type, Print) MD 21208 KERZN nD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () [State
Registrer AMEND ITEM #10b&d PER FH G830 4/27/Qentificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** INNIG /Medical 4b. City, Town, or Location of Death Neme (If not institution, give street and Examiner timor If Under 24 Hrs. Birthplace (State or Foreig Country) 8. Dete of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Min 1 M 2 1 Director 10 Usual Residence of Deceden death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23e or 28a-t ehow N/A XX Yes 2√No Funeral Director mor 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number PARKWAY #502 21218 U.S.A. ONE EAST UNIVERSITY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. th and Mental Hygiene. 27 Ie marked other than "natural", or item treumatic event, it a Medical Examine. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 **BOOKKEEPER** RETAIL DEPT. STORE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **JACOB** CATOR EVA SIBBLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ONE EAST UNIVERSITY PARYWAY #502 BALTO. MD 21218 MITCHELL CATOR / BROTHER 20b. Place of Disposition (Name of ANSHE EMUNAH – AITZ CHAIM 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Pages Department of simportant: It it any injury or o 1 Burial 2 Cremation
4 Donetion 5 Other (5 3 Removal from State CHAIM 04/25/2004 BALTIMORE, MD 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, necession each line. 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final CANCEIR WITH **Physician** BREAL disease or condition resulting in death) /Medical Due to (or as a consequence of) MEIASTASIS Examiner ANAEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) DECLINE The law requires that the death certificate be executed PROGRESSIVE that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by (23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certilicate 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ☐ No 4 Universing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 28c. Injury at Work? 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funerel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D 31464 MD 24/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALT. MD 2/201 N. EUTAN ST Snite 308 SHOAII3 A. IM HZ AH MD 821

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 7 2004

32. Registrar's Signature

			1 - For State Registrar	State of Ivi		ertificate of Death		Reg. No.	13139
	Physici /Medic		Decedent's Name (First, Middle,	Last) Doroth	y Brown	Deloatch	APRIL	Day Year	3. Time of Death 4 8: 28 PM
	Examir		4a. Facility Name (If not institution,	give street and number)	CARE	4b. City, Town, or Location of BALTIMOR	ZE	4c. County of Dea	
	Funeral Director		5. Social Security Number 218-26-6343 Usual Residence of Decedent		e (In yrs. last birthda 73 Yrs.	/) If Under 1 Year If Under 24 Months Days Hours	Min. (Month, Da	9. Bin (V. Year) C	rthplace (State or Foreign ountry) Md
	ryland how		10a. State 10b. County		10c. City, Town or	Location			10d. Inside City Limits
	he Ma 8a-f s	Director	Md	N/A	Balto				1 Yes 2 □ No
	with the		10e. Street and Number	G b b		10f. Zip Code		10g. Citizen of What C	ountry?
	death	Funerai	2211 N. Ellamont 11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	21216 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	n? (Specify Yes or No-	USA 14. Race - Am	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itiam 27 is marked other than "natural", or Itams 23s or 28s-f show or other traumatic avent, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced		No	1 ☐ Yes 2 ☐ No Specify:	Puerto Hican, etc.)	Black, Whi	Black
15-0	"natu	ietec	15. Decedent' (Specify only highest	Education grade completed)	16a. Dec	edent's Usual Occupation e kind of work done during most o DO NOT use retired)	of working	16b. Kind of Business	/Industry
212	filed within Hygiene. Ithar than "	Completed	Elementary/Secondary (0-12) G. E. D	College (1-4or 5	5+) /A	Nurses Aide		Long Ter	m Care
nd	al Hyg d othal	Be C	17. Father's Name (First, Middle, L		/ A	18. Mother's	s Name (First, Middle,	Maiden Sumame)	
yla	should be and Mental I s markad or umatic ava	70	George Han				ed Brown		
Mai	and 2 sho ealth and n 27 is mu		19a. Informant's Name/Relationsh Veronica Deloa			ling Address <i>(Street and Number o</i>		1to, Md 21	,,
ore,	of Health of Health litam 27		20a. Method of Disposition		20b. Place of Disp	And the second s	Date	20c. Location - City or	
Baltimore,	Pages tment of htant: If its jury or of		1 Burial 2 □ Cremation `4 □ Donation 5 □ Other (Sp	ecify)	King Me	morial Park	4-25-2004	Randal1st	own, Md
Bal	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service L	John.	m \	22. Name and Address of Facility 4300 W	March F/H abssh Aven	West ue Balto, 1	MD 21215
			23a. Part1. Enter the disease, or of shock, or heart failure. List of			_		rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	a consequence of):	L INFARCTIO	H		IWEEK
	Examiner		Cognostially list conditions	b.	a consequence or,				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		a consequence of):				
<u>,</u>	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				
68760,	tificate be executed in physician and as the burial-transit	Aedicai		d					
		/Med	IF FEMALE:	23c. If yes, outcome	of organizacy				
P.O. Box	The law requires that the death cert ite has been signed by the attending bage 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
	es that igned b be deta		Part II. Other significant condition			underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord	w requir been si should	eted	CONGESTIVE		ALURE	1010=0=======		es 2 □ No 3 □ Pr	robably 4 Onknown
Division of Vital Records,		Completed by	HY PER CHOI			HYPERTENSI	autop:	sy prior to	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	Death (Check only or		
10	ding Phys h. After this funeral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	y 28b. Time	of 28c. Injury at		ence 6 Other (Spe ow injury occurred	cify)
sior	Attsnding r death. actor: After by the fune	atio	1 Aatural 5 Pending 2 Accident investiga		Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
DIVI	for Att after d Diract I in by I	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, s c. (Specify)	treet, factory, office	28f. Location (S. City or Town	treet and Number or Ru n, State)	ural Route Number,
	To the Hospital or Attsndi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best caminer: On the basis of and manner sta	examination and/or i	th occurred at the time, date and provestigation, in my opinion, death	place, and due to the coccurred at the time, d	ause(s) and manner as ate and place, and due	s stated. In to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier		1/0241	29c. License number		9d. Date signed (Mont	
•	10		Muyly.	MURTAZA		1 10.0	00	APRIL 17	2004
	V		30. Name and address of person w MURTALA KA2M	i ST. AGN	JES HEALT		CATON AV	ENUE BALT	MORE MD. 212
	Sta Registr	113111	31. Date filed (Month, Day, Year) APR 2 7 200		ar's Signature	Sooks .			

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	partment of Hertificate of I	lealth and M		gene on the 2	13140
			Negistrar Negeodent's Name (First, Middle, L.)	ast)		ortinoate or i	Joann	2. Date of Death		3. Time of Death
	•	sician		James	Sherman	Dorsey,	Tr	APRIL	Day Yeer	1 10.00 PM
		edical miner	4a. Facility Name (If not institution, gi	ve street and number)	Diferman	4b. City, Town, or	Location of Death	731 (8)	4c. County of Deat	
			GOOD SAMARI	TAN HOS	PITAL	BALT	IMORE		NA	
	Fune	ral	,	Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Direc	tor	214-50-7561 Usual Residence of Decedent	TO STATE OF THE ST	56 Yrs.			7-12-		Md
	land	4	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary -fsh	ξ	Md N/	A	Baltime	ore				Y⊟Yes 2 □ No
	ath with the Marylan 23a or 28a-f show	by Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	th wit	a D	1642 Northgate	Road 2nd F1	lor		21218		USA	
	r dea		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
-	36 safte	Ž.	1 Never Married 2 Married	1 ☐ Yes 2/XNo If Yes, Give	0	1 ☐ Yes 2 ☐ No	Specify:		0	31ack
W.	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene "naturel", or Items 23a or 28a-1 show	d ba	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's B	Year or Dates:	16a Dec	edent's Usual Occupa	ation	1	6b. Kind of Business/	
RS	72 m 72	Completed	(Specify only highest gi	rade completed)	(Giv	re kind of work done of DO NOT use retired	during most of worki)	ng '		
0 8	d 212 filed withi Hygiene. other than	0	12th grade	College (1-4or 5+ 2 vrs	. Se	curity			Convention Convention	Center
	land and land be filed ental Hyg	Be	17. Father's Name (First, Middle, Las	()			18. Mother's Name		faiden Sumame)	
	arylai should b ind Ment s marked	To E	James S. Dorse	y, Sr			Blanche	Gross		
TAMES	0 0 0		19a. Informant's Name/Relationship						City or Town, State, 2	lip Code)
	re, M s 1 and 2 f Health itam 27 i		Jetheda Dorsey 20a. Method of Disposition	-Daughter		2 Northga				Your State
H.	Baltimore, permit. Pages 1 ar Department of Hea Important: If item	5	1 X Burial 2 ☐ Cremation 3			position (Name of rematory or other place	l		oc. Location - City or	Town, State
C	ting it. Properties		*4 □ Donation 5 □ Other (Spec 21. Sunday of Funeral Service Line		1111	n Cemeter			Balto Co,	Md
	Balt permit. Departr Importe	Suc	R		0	22. Name and Address	•		F/H West nue Balto,	MJ 21210
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused t	the death) Do not e	nter the mode of dying				Approximate Interval Between
	Physici	an	Immediate Cause (Final							Onset and Death
	/Medic		disease or condition resulting in death)	Due to (or as a	consequence of):	HKICKIU.	DISEA	CE CAK	DIOVASCU	LAIL
	Examin	ier	One continue has an editions	b	,		שובניק	>6		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	8760, cate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C						
7	60, be ex		land and a second	Due to (or as a	consequence of):					
	387 icate	dlcal		d						
	ox 6 certifii oding u	/Me	IF FEMALE:	23c. If yes, outcome o	f pregnancy				23d. Date of deli	veo.
i	that the death certified by the attending a	ciar	23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
	of the	hys	9 Unknown	9□ Unknown						
1	S, F ss tha gned l	Completed by Physician/Me	Part II. Other significant conditions	contributing to death but	t not resulting in the	underlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
·	cords, requires been sign	Pe	SEPSIS					1 ☐ Yes	s 2□No 3□Pro	obably 4 Whiknown
	lawre as be	plet	DIABETES N	1ELLITUS				24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
	The I	Son						perform	ed?/// death?	2□ No
;	/ita cian: entific	Be	25. Was case referred to medical examiner?	11int			26. Place of Death	(Check only one,)	- Inst
,	Of O Physic this c	ပ	1 Yes 2 No	Hospital: 1 Impatien			4 Nursing Hon		nce 6 Other (Spec	nify)
	ding After	S S	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Work	at :? ∕es 2 □ No	28d. Describe how	v injury occurred	
	Division of Vital Records, to attanding Physician: The law requires thater death. Director: After this certificate has been signed in by the timeral director, name 2 should be at in by the timeral director, name 2 should be	fica	3 Suicide 6 Could not		v - At home, farm, s			28f. Location (Stre	eet and Number or Ru	ral Route Number,
	Div	Certification:	4 Homicide	building, etc.	(Specify)	street, factory, office		City or Town,	State)	
	Division of Vital Records, P.O. Box 6 To the Hospital or Attanding Phyaician: The law requires that the death certific within 24 hours after death. To the Funarel Diractor: After this certificate has been signed by the attendings of mineral friends director, above 2 should be detached for use as	SalC	29a. Certifier 1 Certifying P	hysicien: To the best of	my knowledge, dea	ath occurred at the time	e, date and place, a	and due to the cau	use(s) and manner as	stated.
	To the He within 24 To the Fe	ledical	one)	miner: On the basis of e	ed.					
	To To 1	Σ	29b. Signature and title of certifier	1		29c. License	number	290	d. Date signed (Month	, Uay, Year)
	1		14	ar -	-	1260	539		7-19.	04
	/	V	30. Name and address of person who	0			1 - 2 11	altmore		001
		State	31. Date filled (Month, Day, Year)	32. Registrar		st., Suite	308,5	autimovi	R/MD 2	1707
	Red	istrar	4DD 9 77 2004	he dera	4	land.	-			

			1 - For Amend Items 9,11,12,	13,13,16	aryland (8) foa a,6,17,18, foa Cei	intment of He , b, 20a, b, 21 tificate of L	ealth and 1 22per FH,0 eath	4ental Hygie 831,05/07/0	ne 2004	13141
s	Physici		1. Decedent's Name (First, Middle, Last) Joseph Diorio					2. Date of Death Month April 13	Day Year	3. Time of Death 3:15 PM M
1	/Medic Examir		4a. Facility Name (If not institution, give stree Fort Washington Hos			4b. City, Town, or Fort Was	Location of Deeth	INPLIE IS	4c. County of Death Prince G	eorge's
1000	Funeral Director		5. Social Security Number 5.79-18-6613 6. Sex 1 ☑ M Usual Residence of Decedent		e (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Sept 12,	9 Rirth	place (State or Foreign
	Maryland a-f show	tor	10a. State 10b. County MD Prince Ge	orge's	10c. City, Town or Lo Bran	cation ndywine				10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 28 unt be no	ral Direc	10e. Street and Number 3100 Danville Road			10f. Zip Code	20613		Citizen of What Cou	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Madical Examinational De notified at ance.	Completed by Funeral Director	1 A Never Married 2 Married	Vas Decedent Armed Forces? AYes 2 ☐ I f Yes, Give /ear or Dates:	Ever in U.S unk 13. No. WWIII		spanic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: whi	etc.
21215-0036	within 72 ho ane. than "natur	mpleted	1		(Give life. L	ent's Usual Occupat kind of work done du OO NOT use retired)	tion uring most of work	ing	Kind of Business/In	- unk
land 2	uld be filed Mental Hygie irked other itic event, II	To Be Co	17. Father's Name (First, Middle, Last) Luzis Diorio		112)			e (First, Middle, Maid 11a Salanone	den Surname)	unk
, Mary	and 2 sho ealth and A n 27 is ma		19a. Informant's Name/Relationship (Type, Forest Nash 1977)	Print) Pital	Delice of the last	0	ad Number or Run	al Route Number, Ci wine MD 206 Wash	ity or Town, State, Zip 13 1ngton, M	Code)
Baltimore, Maryland	tment of Hument of Hument; If iten		20a. Method of Disposition 1 □ Burial 2 MCremation 3 □ Remo '4 □ Donation 5 MOther (Specify)	ı state	- Kalas Crema	natory`or other place, I tory	04/27	/04 Ed	e. Location - City or To	
Bal	permit. Departr Importe any inji		21. Si natum of Superal Service Licensee RON2 Ld Vicensee	Hill	TWR Ba	ltimore,	$\begin{array}{ccc} \text{MD} & \text{RD} & \text{PG} \\ \text{MD} & 2120 \end{array}$	1 6160 Oxon	Funeral Hou	xon Hill, MD
	Physician /Medical Examiner burial-Itausit is the purial-Itausit sthe provided the second of the sec	dlcal Examiner	shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentiary list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as	a consequence of): a consequence of): a consequence of):				2.67,	Interval Between Onset and Death
P.O. Box 6	ne death certif the attending hed for use as	Physician/Med	in the past 12 months?	yes, outcome Live birth Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)		80-2120	23d. Date of delive	ery Day Year
ords, P.	w requires that the state of th	by	Part II. Other significant conditions contribu	ys fu.	netions			23e. Did tobacc	co use contribute to the	ne cause of death?
al Reco	ilcien: The law r certificate has be rector, page 2 sh	Completed	Demend	(Z.A				24a. Was an autopsy performed 1 Yes 2	? prior to con death?	psy findings available mpletion of cause of
Division of Vital Records,	or Attending Physics death. Irector: After this by the funeral dis	Certification: To Be	25. Was case referred to medical examiner? 1	e 6 □Other (Specify njury occurred and Number or Rura ate)						
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Physicia Check only one) 2 Medical Examiner:	n: To the best of On the basis of and manner sta	examination and/or inv	occurred at the time estigation, in my opir	, date and place, a nion, death occurr	and due to the cause ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
İ	To t To t Com	≊	29b. Signature and title of certifier			29c. License :			Date signed (Month, 4-14-04	.1
Spec	Sta	te	30. Name and address of Jerson who imple Dr. Edgar Pott ex 31. Date filed (Month, Day, Year)	1328	eath (Item 23a) (Type, I Southern ar's Signature	Avenue	, S.E.	Washingto	4-14-06 n D.C. 2	2003 2
	Registr	_	APR 2 7 20	41	eleas de	Course				

DHMH 17 Rev 1/2001

ORIGINAL

				a PER FH G8230 4/27/004	Hificate of Death	Reg. I	No.
	Physici	an	1. Decedent's Name (First, Middle, Last)	44001			Day Year 05:44 A M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		6, 2004 05.79 AM
	LXamiii	CI		OF BALTIMORE	BALTIMORE		NA
	Funeral Director		110-20-202	M 200F 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 8. Birthplace (State or Foreign Country)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location		10d. Inside City Limits
	ith the Marylar or 28a-f show	tor	MD Battin	pore.	Battimore.		1 ☐ Yes 2 X No
	or 28	Olrec	10e. Street and Number	0 0 1 1 1 1 1	10f. Zip Code	10g.	Citizen of What Country?
	sath w	eral	103 VIIIage of	2. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp	and Van or No	14. Race - American Indian,
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exercites must be rediffied at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	Amed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc.
5-0036	2 should be filed within 72 hours all and Mental Hygiene. is marked other than "natural", or raumatic event, the Medicul Evern	d by	3 Widowed 4 □ Divorced			101	Specify: BIACK
-51-2	n nat	Completed	15. Decedent's Educity only highest grade	completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	king 16b.	. Kind of Business/Industry
Maryland 2121	ad with giene ar tha t, the	Com	12th GRADE	College (1-4or 5+)	school Teacher	F	Batto. City
and	be file	Be	17. Father's Name (First, Middle, Last)	etcher Tumpi	18. Mother's Nam	e (First, Middle, Maid	den Sumame)
ryk	should be nd Mental markad c	٩	AURTT)UK TI		iling Address (Street and Number or Ru	TINE City	ty or Town State Zip Code)
	alth ar 27 is ar trau		Marcia A. Ros	s (Daughter) 103	Lund Dive C+#	10 Palto	.MD 21244
3altimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra ance.		20a. Method of Disposition 1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	amoval from State 1/2 - A	position (Name of ematory or other place)	Date 20c.	Location - City or Town, State
ţ	t. Pag tment rtant: I	-	4 Donation A Other (Specify)	Greenil	Nount Cremeton 5	3-04 K	attimore mo
Ba	permi Depar Impor any ir		21. Signature of Funeral Service License	o Ma	22. Name and Address of Fability	ugho CG	veen fundal Suc
	· ·		23a. Part1. Enter the disease, or compli	cations that caused the death. Do not el	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Behavior
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition		BREAST CANCER		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	0 0 1 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	•	
В	LAUMME	0	Sequentially list conditions, is any, leading to immediate	. Due to (or as a consequence or).			
	od d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
0,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a consequence of):			
68760,	cate b physic the bi	Medical					
-	certifii nding p		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery
. Bo)	that the death co	Physiclan/	in the past 12 months?	4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.0.	at the	Phys	9 Unknown	9□ Unknown		00. 0:111	
ds,	law requires that as been signed b 2 should be det	þ	Part II. Other significent conditions con	tributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
cor	w requ	lete				24a. Was an	
Re	The lav	Completed				autopsy performed	
/ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			th (Check only one)	
of \	Physic this c	2	1 ☐ Yes 2 Z No H	ospital: 1 Inpatient 2 ER/Outpatie	90.00	ome 5 Residence	
o	th. : After s funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		Zod. Describe now in	gury occurred
Division of Vital Records,	r Attandi er death. ractor: A i by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	pital o						
	bo ho ho	edical	29a. Certifier (Check only one) 1. Certifying Physical Examination (Check only one)	ician: To the best of my knowledge, dea ler: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)
	24 24 8 F	Ų					
	To the Hospital or Attanding Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Med	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	To the H within 24 To the Fi complete	Med	29b. Signature and title of certifier Modes, 30. Name and address of person who co	00	RES-000	A	Pril 26, 2004

State Registrar

DENTON, PHYLLIS T

PATIENT KNOWN RS

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 7 2004

sicia		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time o	Death
dica	1	Allie		verett			4	_16_	04		30 MPM
mine	r	4a. Facility Name (If not institution, give s	street and number)			r Location of Deatl	h		unty of Death		
		Caton Manor 5. Social Security Number 6. Sex	7. Age /	(In yrs. last birthday)	Bal1	timore If Under 24 Hrs.	8. Date of Birt	6/1./1	N/A 915 9 Birth	place (State)	v Foreign
ral or			M 2 X F 88		Months Days	Hours Min.	(Month, Day	V. Year) 1	N.C	aroli	na
		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo	· · · · · · · · · · · · · · · · · · ·					10d. Inside C	he Limite
	.			•							2 □ No
	Director	Md. N/A		Baltir	nore 10f. Zip Code			10a. Citizer	of What Cou		
į		820 S. Caton A	ve.			229		US.		,	
	Funeral		12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H		pecify Yes or No-		Race - Ameri Black, White,		
1	2	1 Never Married 2 Married	1 ☐ Yes 27 ☐ No If Yes, Give		1 ☐ Yes 2 X No					lack	
:	ag pa	3 Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:		dent's Usual Occup	etion			of Business/Ir		
	Completed	(Specify only highest grade	e completed)	(Give	kind of work done DO NOT use retired	during most of wor	rking	100, King	or pasinessyii.	idustry	
	E	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker			Но	me		
	De	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Su	тате)		
i	0	Nathan Hyma				Matt			Hymai		
	1	19a. Informant's Name/Relationship (Type	,		ng Address (Street						
		Edward Basemor 20a. Method of Disposition	e Nephew	20b. Place of Disco	4 Merryn		r.Balti Date		Mary.		
once.		1 ⊠Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory or other place on Cem.	4-22			drowne		
oi	-	21. Signature of Funeral Service License	98								_
Succe		Lloyd M Es	tep	1	Estep Br L300 Eut	rothers caw Plac	runera e.Balt	I Sem	r,P.A. e.Md.	2121	7
		23a. Part I. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	e death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory an	rest,	,	Approximat Interval Bet	9
,		Immediate Cause (Final disease or condition	Endera		tiple M	Holama				Onset and	
1		resulting in death)	Due to (or as a	consequence of):	0	1				7	3
r			Due to for on a								
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (01 as a t	consequence of):							
	Examiner	that initiated events cresulting in death) Last	Due to (or as a c	consequence of):						,	
	Ca										
		IF FEMALE:									
1	25	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnancy			23d.	Date of delive	,	rear
	Puysicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tin 9☐ Unknown	ne of death 5 L	Other (specify)					,	
d	7 .	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of c	eath?
	o po						1 □ Y	es 2 🗆 N	o 3 ☐ Prot	oably 4 🔀	Inknown
	Diete						24a. Was a	ın 2	4b. Were auto	psy findings	available
							autops perfor	med?	prior to co death? 1 Yes	mpletion of c -2134No	ause of
	Ę						th (Check only or	18)			
	ນ	25. Was case referred to medical				or	ome 5 Resid	ence 6 🗆	Other (Specif	(y)	
	0 00	examiner? 1 ☐ Yes 2 ☑No	ospital: 1 Inpatient		it 3□ DOA Oth	4 V Nursing H			an seemed		
	0 0	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y		28c. Injun Worl	/ at k?	28d. Describe h		curred		
	0 0	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Injun Worl	/ at	28d. Describe h	ow injury oc		Al Route Num	her
	0 0	examiner? 1	28a. Date of Injury (Month, Day Y	28b. Time of Injury At home, farm, str.	28c. Injun Worl	/ at k?		ow injury od		al Route Num	ber,
Label and Complete Co	Certification: 10 be	examiner? 1	28a. Date of Injury (Month, Day Y	28b. Time of Injury At home, farm, str. (Specify)	28c. Injun World M 1 0	/ at ⟨?⟩ Yes 2 □ No	28f. Location (S. City or Town	treet and Non, State)	umber or Rura	tated	
Later Control of the	Certification: 10 be	examiner? 1	28a. Date of Injury (Month, Day Y 28e. Place of Injury building, etc. (28b. Time of Injury At home, farm, str. (Specify) Try knowledge, death camination and/or my	28c. Injun World M 1 0	/ at ⟨?⟩ Yes 2 □ No	28f. Location (S. City or Town	treet and Non, State)	umber or Rura	tated	
Land of the seco	legical certification: 10 be	examiner? 1	28a. Date of Injury (Month, Day Y 28e. Place of Injury building, etc. (ilcian: To the best of eler: On the basis of eler.)	28b. Time of Injury At home, farm, str. (Specify) Try knowledge, death camination and/or my	28c. Injuny Worl Deet, factory, office	y at √? Yes 2 □ No ne, date and place pinion, death occur a number	28f. Location (S City or Town , and due to the c rred at the time, d	treet and Non, State) ause(s) and pla	umber or Rura I manner as si ce, and due to	tated. o the cause(s	
Later Control of the	legical certification: 10 be	examiner? 1	28a. Date of Injury (Month, Day Y 28e. Place of Injury building, etc. (ilcian: To the best of eler: On the basis of eler.)	28b. Time of Injury At home, farm, str. (Specify) Try knowledge, death camination and/or my	28c. Injuny Worl Deet, factory, office	y at √? Yes 2 □ No ne, date and place pinion, death occur a number	28f. Location (S City or Town , and due to the c rred at the time, d	treet and Non, State) ause(s) and pla	umber or Rura I manner as si ce, and due to	tated. o the cause(s	
Later Control of the control of the	Medical Certification: To be	examiner? 1	28a. Date of Injury (Month, Day Y 28e. Place of Injury building, etc. (idician: To the best of the serior of the basis of eyen and manner state) mpleted cause of dea	28b. Time of Injury At home, farm, str. (Specify) my knowledge, death camination and/or ind.	28c. Injuny Worl Deet, factory, office	Yes 2 No Ne, date and place pinion, death occur a number The pitul	28d. Describe h. 28f. Location (S. City or Town.), and due to the corred at the time, d.	treet and Non, State) ause(s) and pla	d manner as s ce, and due to gned (Month,	tated. o the cause(s	

			1 - For Stete Registrar	State of	f Marylar		artment o			Mental Hyg	iene 2 (004	13144
	Physici		1. Decedent's Name (First, Middle, Las Terry W. Edmond	·						2. Date of Dea Month April		Year 2004	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and nun	•		-		ation of Death	-		ty of Death	1:15A ^M
	Funeral	81	St. Elizabeth Nu 5. Social Security Number 6. S		ome 7. Age (In yrs.	last birthday)	If Under 1 Y	altin	nder 24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Foreign
	Director		217-10-0936	□M 21X F	8		Months D	ays Ho	ours Min.	Aug. 4,	Year)	Mary	lace (State or Foreign try) Land
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					1-	0d. Inside City Limits
	Be-f st	Director	Maryland Baltimo	re		Cato	nsvill	е					1 ☐ Yes 21 No
	a or 2	Dire	10e. Street and Number	_			10f. Zip Co			1	0g. Citizen o		•
	death ms 23	Funeral	413 Wheaton Plac	12. Was Dece	dent Ever in U	.S. 13.		21228 of Hispan		pecify Yes or No- o Rican, etc.)		U.S.A.	
36	permit. Pages 1 and 2 should be tited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any righty or other traumatic event. It's Modified Exe. vill ref. wal be inclified at ODCe.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🚰 Divorced	Armed For 1 Tyes If Yes, Giv Year or Da	2 점 No e		lf Yes, specify 1⊡ Yes 2150			o Rican, etc.)	Spec	ack, White, with	ite
Maryland 21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual O kind of work d	one durino	most of wor	kina	16b. Kind of		
121	within ene. than "	dmo	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use n	etired)			Tifo	T	
1d 2	tiled Hygid other	Be Co	17. Father's Name (First, Middle, Last)			Seci	ecary	18. [Mother's Nan	ne (First, Middle, I	Life Maiden Suma		nce
ylar	ould be Menta arked atic ev	To B	Raymond Paul Wa						Dora l				
Mar	d 2 shoth and 7 is m		19a. Informant's Name/Relationship (Thelma R. Holbroo		htorl					nsville,			Code)
re,	s 1 an f Heal itam 2 other		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name on natory or other	of	e care		20c. Location		wn, State
Ë	Page ment o ant: if ury or		1 ☐ Burial 2 🖾 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify						ny 4–	27-2004	Laurel	l, Mar	yland
Baltimore,	permit. Daparti Import any inj		21. Signature of Funeral Service Licen	20,		Wi 16	Name and A	ddress of F unera	acility 1 Home	of Cato	nsvill	le, In	c y i and 21228
	Pnysician /Medical Examiner		231 Part1. Enter the disease, or composite the process of composite the process of the process o	aY	aused the deat line. OCAVO or as a conseq	h. Do not ent	er the mode of	dying, suc	ch as cardiac	or respiratory arre	est,	Z	Approximate Interval Between Onset and Death
8760,	Sec.	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Undant of the Cau	c	or as a conseq								
.O. Box 6	The law requires that the death certiticate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		rth 2 ☐ Feta ant at time of d	I death 3	Ectopic pregn Other (specify		771			ate of deliver	ry Day Year
rds, P.	quires that n signed b	by	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	nderlying cause	e given in l	Part I.		acco use cor		e cause of death?
Vital Records,		Completed								24a. Was ar autops perform 1 Yes 2	y	prior to com death?	sy findings available apletion of cause of
	nysicien: Thans certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	Hospital:	npatient 2	ER/Outpatien		0.4		h (Check only on			
Division of	Attending Physicien: r death. ector: Atter this certitics by the funeral director.	-	27. Manner of Death	28a. Date o		28b. Time of Injury	28c.	Injury at Work?	X nursing H	ome 5 Reside 28d. Describe ho)
Sio	ttendir death. stor: At / the fu	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М	1 🗌 Yes	2 🗆 No				
<u>></u>	al or Attendates atter deatl	Certification;	4 Homicide determined	288. Place	of Injury - At hogg, etc. (Specify	ome, farm, str	eet, factory, off	lice		28f. Location (Sti City or Town		iber or Rural	Route Number,
	To the Hospitel or Al within 24 hours atter of To the Funeral Direc completely tilled in by	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicel Exem	ysician: To the niner; On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the	ne time, da my opinion	te and place, death occur	and due to the ca	use(s) and m	nanner as sta , and due to	ited. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	150	MA		29c. Lic	cense num	ber	25	d. Date sign	ed (Month, E	Day, Year)
}	in		alvel WI	white	MIN	020\7	Desire)	123)65		4/23/	04	
	V		30. Name and address of person who	completed cause	M. M.	40.5	Frede	apri	Rd. +	\$ 30Z, Ba	Homer	re, My	85515
	Sta	9.5	31. Date filed (Month, Day, Year)	32; Re	ngistrar's Signa	iture	doort	2	. × 2 1		- 17	-	
ra f.	Registr	ar	NDR 2 7 2004	100		/ /	7						

		4 101	eartment of Health and Mertificate of Death	ental Hygiene	4004 10140
	sician edical	1. Decedent's Name (First, Middle, Last) Charles Fiori		2. Date of Death April 24	y Year 3. Time of Death 0523 A M
A 1875 W	niner	4a. Facility Name (If not institution, give street and number) Harbor Hospital Center	4b. City, Town, or Location of Death Baltimore	40	. County of Death N/A
Funer Directo		5. Social Security Number 212 30 0877 6. Sex 12 M 2 F 7. Age (In yrs. last birthday 72 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 15, 1	9. Birthplace (State or Foreign Country) 931 Maryland
death with the Maryland ms 23a or 28a-f show must be notified at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Anne Arundel Baltime			10d. Inside City Limits 1 ☐ Yes 2X No
or 28a-	Director	10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Country?
6 after death v or Items 23a miner must	Funeral	1 Never Married 2 Married 1 Married 2 No	21225 Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto to 1 ☐ Yes 2 ☑ No Specify:	crify Yes or No- Rican, etc.)	U.S. 14. Race - American Indian, Black, White, etc. Specify: White
Iry/I and 21215-0036 should be filled within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examinating at	Completed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	ng 16b. K	and of Business/Industry
d 212 filled with Hygiene. ther the	Com	12th 17. Father's Name (First, Middle, Last)	neral Contractor	(First, Middle, Maider	onstruction
Maryland d 2 should be file th and Mental Hy i7 is marked othe treumatic event,	To Be	Henry W. Fiori		cle Kirby	,
Magage 17 18			ling Address <i>(Street and Number or Rura</i> Cromwell Street		or Town, State, Zip Code) P. Maryland 21225
Baltimore, M permit. Pages 1 and 3 Department of Health Importent: If Item 27 any injury or other tr		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place of Disposition State 20c. Place	position (Name of Dematory or other place)	ate 20c. L	ocation - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Importent: If Item	ش	`4 □Donation 5 □Other (Specify) MD. Stat		-	ownsville, Maryland
Balt permit. Departr Importe	SUC		1001 Ritchie Highwa		l Service, P.A. ore, Maryland 21225
Company .	8	23a. P. 1. Enter the disease complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
Physicia /Medic	al	disease or condition resulting in death) Due to (or as a consequence of):			
Examine		Sequentially list conditions, if any, leading to immediate b. Pneumonia Due to (or as a consequence of):			
acuted ind transit	Examiner	cause. Enter underrying Cause (Disease or injury that initiated events c.			
. Box 68760, death certificate be executed e attending physicien and id for use as the burial-transit	dicai Ex	Due to (or as a consequence of):			
OX 68 certificat noting phy use as th		IF FEMALE:			
	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
– 2 9 9	þ	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
I Rec The law ate has b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ✓ No Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatie	26. Place of Death	(Check only one)	6 ∏Other (Specify)
VISION OF VITA Attending Physician: If death. ector: After this certific by the funeral director,		27. Mannor of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury (Month, Day Year)	of 28c. Injury at Work?	8d. Describe how inju	
Division of a or Attending Physical death. Director: After this din by the funeral d	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 Yes 2 No treet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
DIV To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by		29a. Centifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause(s ad at the time, date and) and manner as stated. d place, and due to the cause(s)
To I	Ž	30. Name and address of person who completed cause of death (Item 23a) (Type 5. M. Falas at Harbor Hispital Center 31. Date-tileg Month, Par Year) 32. Registrar's Signature	29c. License number P 1 7 7 88	29d. Da	te signed (Month, Day, Year) on £ 24 Th 2004
1	1	30. Name and address of person who completed cause of death (tem 23a) (Type 5. M. Farasar Harbor Mispital Cente	Print) 301 S. Hanover	st. Balhi	nore MD 21295
	State istrar	31. Date-filed (Month, Day, Year) 32. Registrar's Signature	books		

				For Stete Registrer	State of Mar	ryland /	Departi Certi	ment of F ficate of	lealth an <i>Death</i>	d Mental H	ygiene Reg. No	- 007	13146
		sicia	_	Decedent's Name (First, Middle, Las Mary T Frezza	st)					2. Date of D Month	eath 17	ay 200	3. Time of Death
	Exa Fune Direc	tor	er	5. Social Security Number 7 6. S	ex 7. Age 7. Age 86	(In yrs. last b	Yrs.	b. City, Town, of Solid Under 1 Year Months Days	dala If Under 24	2	lirth Day, Year,	9. Bir	th OFE Tholace (State or Foreign ountry) imore City, M 10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show		Director	Maryland Baltimore 10e. Street and Number		Baltim	ore Co	Inty 10f. Zip Code			10g. Ci	itizen of What Co	1 Yes 2 No X
y	`		by Funeral D	4228 Necker Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			21236 s Decedent of Hes, specify Cub		? (Specify Yes or Nuerto Rican, etc.)		SA 14. Race - Ame Black, Whith	te, etc.
,	within 72 hours after liene. than "natural", or the	SAINS	Completed b	15. Decedent's Ec (Specify only highest gra	ducation de completed) College (1-4or 5+))	(Give kir life. DC	t's Usual Occup d of work done NOT use retire Designer	during most of d)	working		Kind of Business	
Mally	I ary i arrio 2 1.2 2 should be filed within and Mental Hygiene. Is marked other than		To Be Co	8 17. Father's Name (First, Middle, Last) Dante Moretti	N/A	E.	IOWEL	resigner		Name (First, Midd		ister Flo Sumame)	CISL
Σ.	e, Mar 1 and 2 sho Health and I em 27 is me			19a. Informant's Name/Relationship (Dente M Frezza 20a. Method of Disposition	Type, Print)		3714		l Drive	Rural Route Num Abington, Date	Micyla		
622A	DEJILITIOTE, MATYIGITIO 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "natural" or	ny mjury or o		1 ⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specification 5) 21. 9ichalure of Funeral Service Licer	y) .		ood Cer 22. N	n. A lame and Addre	pril 21 2 ess of Facility	2004 • Inc.	Palt	tinore, M	
W. OFF	Physic /Medi Examii	ian cal ner	er	23a. Part1. Enter the dia ase, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	plications that cause to one cause on each line a.	rato consequence MDY	not enter	11 Belair the mode of dyi	Road Ral	timore MH	2123 arrest,	36	Approximate Interval Between Onset and Death
	VISION OI VITAL RECORDS, P.O. BOX 08/00, Attending Physicien: The law requires that the death certificate be executed reach. result. scior: After this certificate has been signed by the attending physician and	o the burat-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a d	consequence	9 of):				11-11		
29	r.C. box or nat the death certiff d by the attending		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tii	Fetal deat		ctopic pregnanc ther (specify) _	у			23d. Date of de Month	Day Year
	v requires that	9	ρ	Part II. Other significant conditions of	ontributing to death but	not resulting	in the unde	erlying cause gr	ven in Part I.	_ 1[Yes 2	XNo 3□P	o the cause of death? robably 4 Unknown
<u>.</u>	VITAL MEC sicien: The law certificate has b	V	e Completed	25. Was case referred to medical			M		26 Place of	24a. We aut per 1 Yes	opsy formed? 2 X No	24b. Were as prior to death?	utopsy findings available completion of cause of
	JIVISION OF VICAL RECORDS, to Attending Physicien: The law requires tafer death. Director: After this certificate has been signer.	me runera	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	e One Blace of Injure	Ye <i>ar)</i> 28b.	. Time of Injury	28c. Inju Wo M 1	ner: 4 🗌 Nursir	28d. Describe	sidence e how inju	iry occurred	ural Route Number,
i	5 th 5	completely lited in by		4 Homicide determined 29a. Certifier Certifying Ph	building, etc.	my knowled	ge, death o	ccurred at the ti	me, date and p	City or T	own, State	e) s) and manner as	s stated.
	To the Hospitel within 24 hours a To the Funeret I	completer	Medical	(Check only 2 Medical Exerone) 29b. Signature and title of certifier	niner: On the basis of e	ed.		29c. Licens		occurred at the time	29d. Da	ate signed (Mont	
	(5)			30. Name and address of person who	completed cause of dea	_		ivare I	181	Saltimor		110/04 110/04	237
	Re	Sta gistra	-	31. Date filed (Month, Day, Year)	32. Registrar			oails	•	<u> </u>	, ,,	,	V J

			1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H	ealth and N Death		giene2 ()	04 13147
	Physic /Medi		1. Decedent's Name (First, Middle, L	asi)	ulda	01/		2. Date of De Month		Year 2039 M
	Exami		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or Ball	himo	200	4c. County NA	of Death
1	Funeral Director		5. Social Security Number 6. 252-20-9612 Usual Residence of Decedent	Sex 7. Age (In 1 M 2 F 81	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	y, Year)	Birthplace (State or Foreign Country) Ga.
	h the Maryland or 28a-f ehow or cliffed at	Director	10a. State 10b. County Md. Balti 10e. Street and Number		c. City, Town or Lo				10g. Citizen of W	10d. Inside City Limits 1X Yes 2 □ No What Country?
336	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show he Madical Exteriment result by rotified at	by Funeral	2500 Old North 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces?	1	2122 Vas Decedent of His f Yes, specify Cuban		pecify Yes or No Rican, etc.)	USA 14. Race Black Specify.	e - American Indian, k, White, etc. : Black
Maryland 21215-0036	7 G L 20	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12th grade	rade completed) College (1-4or 5+)	(Give	lent's Usual Occupal kind of work done do DO NOT use retired)	uring most of work			siness/Industry
yland	be de la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, Las Noah	Swair	1		18. Mother's Nam Mollie		Maiden Sumame Munfo	
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1	To the within 2 To the comple	Me	29b. Signature and title of certifier	A. Anh	MD	29c. License r	number 360	2	9d. Date signed	(Month, Day, Year) 25, 2004
	Sta	te	30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of death (// // // 55 32. Registrar's Si	05 HOP	PILINS B.	AYVIDI	v Cir	ce B	ALTIMORE ZIZZZ
DHI	Registra	ar	APR 2 7	2004 Siene	wa B	Loon	1			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 13118 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear **Physician** GRIM 332 PM MPRIL 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA HOPKING BAYVIEW MEDICAL CENTER BALTIMORE JOHN9 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) Year) 1928 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2□ F 75 219-20-4744 November 24, Director MD. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , or items 23a or 28a-f ehow grainer must be notified at 1X Yes 2 No N/A Baltimore Direct 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 21224 USA 20 North Luzerne Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: à 3 Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4or 5+) Elementary/Secondary (0-12) Deputy Sheriff Baltimore City 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is 1 and 2 should be fit of Health and Mental Hy flem 27 is marked oth Sarah Irene McGowan Arthur Marvin Grim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) wife 20 North Lazerne Avenue, Baltimore, MD. 21224 Louenna Grim April 30, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of the importent: if ite 1 № Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oak Lawn Cemtery 2004 Dundalk, MD. ^{22. Name and Address of Facility}
Connelly Funeral HOme Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21. Signature of Funeral Service Licensee 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9 MONTHS **Physician** FIBROGING ALUEOUITIS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) death certificate be executed Due to (or as a consequence of) use as the burialthe attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? 2 ATHEROSCUEROTIC CORONARY ARTIERY DISEASE CONGESTIVE HEART 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No FAILURE. DIABETES 24a. Was an autopsy performed? certificate 1 Tyes 2 No Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ■ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide within 24 hours a 🖶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 APRIL 26. MD 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOO NORTH WOLFE YT 1. GAVIN HAMILTON DEPT. OF MEDICINE JOHNS HOPKINS HOSPITAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 7 2004 Registrar

			1 = For State Registrar	State of Ma	aryland /	Depa	rtment tificate	of He	alth a	nd Men	tal Hygi	ene200	4	13149
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Las	lel i nda	GEIST		4b. City, T	own, or Lo	ocation of	Ap	Date of Death		ar	3. Time of Death 10:50 A ^M
	Funeral Director	er	259 Wheeler School 5. Social Security Number 6. Se	ol Road	o (In yrs. last b. 91	irthday) Yrs.	Py If Under 1	lesv.		4 Hrs. 8. C	Date of Birth Month, Day, n. 2,	Harfo	Birthplac	e (State or Foreign Ivania
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State Maryland Harford		10c. City, Tov		cation ville			[O 0.				. Inside City Limits 1 □ Yes 2 No
	th with the 23a or 28 ist be not	al Director	10e. Street and Number 259 Wheeler Scho	ol Road			10f. Zip C	21:	132		10	g. Citizen of Wha		?
036	ours after deal al', or Itams	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		i	Vas Decede Yes, specif			in? (Specify Puerto Ricar	Yes or No- n, etc.)	14. Race - A Black, V Specify:	Vhite, etc	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant. Its Medical Exam. In a must be notified at once.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12		+)	(Give :	ent's Usual kind of work OO NOT use emaker	done duri retired)	on ing most o	of working	1	6b. Kind of Busin		stry
yland	should be file and Mental Hy s marked othe umatic evant,	To Be C	17. Father's Name (First, Middle, Last) James Irvin Kuntz					ı	Mary	Celes	te Res			
, Mar	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (7 Mary Ann Harvey/D		2	59 W	heele	r Sch		Road,	Pyle	City or Town, Sta. sville,	MD	21132
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of comete Highv	riew	Mem.	Garde		Date 4-26-0	4 F	allston,		, State
Ba	permi Depar Impor any ir		21. Signature of Fundral Apprice Licens	tening		- 50) W. B	roadt	wav S	Home, Street	. Bel	Air, MD		
760,	Physician //Medical Examiner portion and portion francial provided provid	cal Examiner	23a. Part1. Enter the disease, or compshock, or hear failure. List only of the compshort of	a. Due to (or as: b. Due to (or as: c. CON	A BETT	E S (a) of): (a) of): (b) VE	102				UR		Int	oproximate terval Between nset and Death
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Division of	ttending death. stor: Afte the fune	Certification;	27. Manner of Death 1 Vatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day 28e. Place of Inju		Time of Injury	М		s 2□No	0		r injury occurred	Cural Co	nute Alumba
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	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	Medical	(Check only one) 2 Madical Exam	iner: On the basis of and manner sta	examination a	nd/or inv	estigation, in	n my opini License ni	ion, death	occurred at	the time, dat	e and place, and	due to the	e cause(s)
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	/,		30. Name and address of persen who can be seen as a seen and address of persen who can be seen as a seen and address of persen and address of persen and address of persen and address of persen and address of persen and address of persen address of persen and address of persen and address of persen and address of persen address of pe	AVITE M	eath (Item 23a)	563	29 L	ous	COR	NEN	Rom	WHITE	Ital	/MD
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 2004	Servino	19	pla	park	2						201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL. Audrey R. Hilton 2004 9:50 pM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Catonsville Catonsville Baltimore Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 XF 212-07-8338 90 APR 2, 1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 Yes 2 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Garden Ridge Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ₹ No Specify: Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Rowley Ethel Albright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra H. Rabel/Daughter 100 Garden Ride Road Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. View Cemetery 4-27-04 Marriottsville, MD 21. Signature of Funeral Service Toolse McDonald

Dawn F. McDonald ^{22, Name and Address of Facility}
MacNabb Funeral Home, P.A.
301 Frederick Road Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEPSIS resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

The law requires that the death certificate be executed P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0036

Completed by Funeral Director

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Certification:

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29a. Certifier

(Check only one)

signed by Division of Vital Records, has been this certificate To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica

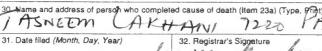
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ASNEEM 31. Date filed (Month, Day, Year) APR 27

29b. Signature and title of certifier

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and manner stated.

156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28595

HEICHTS

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:54 P. M 25 April 2004 Mildred A. Hawkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel Millennium Health & Rehab. Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth June 16, 18, Year 932 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F 71 Maryland 215 28 0856 Director Usual Residence of Decedent death with the Manyland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location r than "netural", or itame 23a or 28a-f show 1 Yes 2 □ No Baltimore N/A Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. 21226 1615 Filbert Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: δ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker s 1 and 2 should be fited w f Heatth and Mental Hygien item 27 is marked other th 8th other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary (not available) Ignatz Zukaitis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other treu Baltimore, Maryland 21220 Frank Savitski / Nephew 1542 Chilworth Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4/27/2004 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway MULLE 23a. Part1. Enter the disease, or complications that edused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** OBS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician the for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? ģ P 2 🗆 No 3 Probably 4 Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification: To 1 ☐ Yes 2 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospitei 1 🕑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number Se of fleath (Item 23a Type, Pro 410 HIGHWAY, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 7 2004 Registrar

			1 - For State Registrar	State of Ma	ryland / Dep		of He	alth and	F	leg. No.		13152
15	Physici	an	Decedent's Name (First, Middle, Last)	~ · · · · ·		(T) 3			2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al			e Eleanor				April	1	004	7.35 A. ^M
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2.			Harbor Hospital		(In one to at himborn	-	ltimo	ore	rs o Data at Bird			
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Control of the Contro	Director		Usual Residence of Decedent		19 113.				August	23,1924	Mary	rland
	land		10a. State 10b. County		10c. City, Town or L	ocation					10d.	Inside City Limits
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	filed within 72 hours after death with the Maryland Hygione. Ither than "natural", or Items 23a or 28a-f ehow int, Ira Medical Evander must be notified a	급	2821 Maisel Stre	e+			21230	1		U.S.	iat Country	ŧ
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8	hour ture	Pe	15. Decedent's Educ		16a Dece	edent's Usual	Occupati	on		16b. Kind of Bus	inocc/leduc	**.
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7	with ene.	Ë	Elementary/Secondary (0-12) 8th	College (1-4or 5-	Hor	nemake	r			Own 1	Home	
2	Hygint, Ind.	ပို	17. Fathar's Name (First, Middle, Last)				1.	8. Mother's N	ame (First, Middle,			
a	d be) Be	Bryan Ka	line					dia Whoo!			
2	hould d Me mark matk	ဥ	19a. Informant's Name/Relationship (Ty)		10h Mail	ing Address	(Street and		Rural Route Numbe		tata Zia Ca	uda)
Maryland 21215-0036	d 2 s h an 7 le		Catherine M.H. Ro					Avenue		nore, Ma:		
	1 and Health Hm 27 thar to		20a. Method of Disposition						Date	20c. Location - C		
ō	Pages nent of P int: If its iry or of		1 ☐ Burial 2 【SCremation 3 ☐ R	emoval from State	20b. Place of Disp cemetery, cre							
Ε	tant:		`4 □Donation 5 □Other (Specify)		Bayview					Baltimor		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exerciner must be notified a gone.		21. Signature of Funeral Service License	muroce	or la 4	2. Name and 001 Ri	tchi	of Facility (e High	Gonce Fund way Bal	eral Ser timore,	vice, Maryla	P.A. and 21225
760,	Physician /Medical ksician and portial-transit le burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of): consequence of):	Ner	15	Den	uenti	<u>a</u>		years
P.O. Box 68	The law requires that the death certificate be executed ten has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	⊒Ectopic pre ⊒ Other (spe				23d. Date Mont		y Year
	w requires that been signed b should be deta	by PI	Part II. Other significent conditions con	tributing to death but	not resulting in the	underlying ca	use given	in Part I.	23e. Did to	bacco use contrib	unte to the c	ause of death?
Records,	quire n sig uld b	d b	Hypert	ensi	on				1 □ Y	es 2 1 No 3	☐ Probably	4 □Unknown
8	w re-	Completed	1 8						24a. Was a	n 24b. W	are autonsy	findings available
æ	he lav e has	Ĕ							autops	med? pri	or to comple ath?	etion of cause of
Vital	ician: Th certiticate rector, pag	ပိ	25. Was case referred to geodical								Yes 2	146
	Attending Physician: If death. actor: After this certific by the funeral director.	00	examiner?	ospital:	2 7 70	25 00	Other		eath Check on or			
Division of	Phys rthis raldi	7	27. Manne Death	28a. Date of Injury	t 2 VER/Outpatie		c. Injury a	4 Nursing	Home 5 Reside	ow injury occurred		
5	ding F h. After funer	흔	1 Vatural 5 Pending	(Month, Day	Yeer) Injury	М	Work?	s 2 □No				
<u>s</u>	Attendide death.	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e Place of Injur	y - At home, farm, st	-		5 2 110	28f Location (S	reet and Number	or Pural Po	sute Number
\geq	or A atter Dira in by	Ë	4 Homicide determined	building, etc.	(Specify)	ieet, lactory,	Office		City or Town		OI Huiai H	oute Number,
_	pital purs eral filled		29a. Certifier 1 Certifying Phys	inion. To the best of	Lancks and a day			determined to	11			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phys	ner: On the basis of and manner state	examination and/or in	nvestigation,	in my opin	uate and plaction, death oc	ce, and due to the c curred at the time, d	ause(s) and mani ate and place, an	ner as stated d due to the	o. e cause(s)
	thin the	Mec	29b. Signature and title of certifier	and mainer stat		29c	License n	umber	10	9d. Date signed (Month Day	Year)
	5 7 8 H		2010			2.50	1//	1201				
	10		permaen	myn	()	16	141	238	1	tpv.1	26,	2004
	V		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type	A:	0 .	10.	0 1.0	Q .	,	,
	227		J. Olykunony,	MU 30	>1 >+P	and	Dill	time	L, MD	2120	2	
300	Sta Registr		31. Date filed (Month, Day, Year) APR 2 2004	32. Registrar	Signature Apr	nkel						

	ė		1 - For Amend Item # Registrar AMEMD ITEM #1 1. Decedent's Name (First, Middle, Rasi		G830 4/2 4/27/04 9 1 €	7/04 tas entificate of	Death	2. Date of D		104	3. Time of Death
	Physic		Itally 1	Mitte	YVEIT	E HOLLANI)	Month	Day 15	Year	0115 M
•	/Medi Examir		4e. Fecility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Deal		4c. Count	ty of Deeth	2
	Funeral Director			x 7. Age (In	yrs. last birthday 44 Yrs.) If Under 1 Yea Months Days	r If Under 24 Hrs	(Month, D	irth ay, Year) 1, 1960	9. Birthpl Count	lece (State or Foreign try)
	aryland show		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10	0d. Inside City Limits
	the Man 28a-f sh	ctor	MD BALT	IMORE		PARKVII	LLE				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		-M	10g. Citizen of	What Count	try?
	eath y	erai	8453 ARBOR S'	TATION WAY 12. Was Decedent Ever	in U.S. 13	Was Decedent of	21234	Specify Ves or N	0. 14 Ba	US/	A
980	within 72 hours after death with the Maryland ene. than "netural", or itams 23a or 28a-f show ita Madical Exertir et maral be notified at	by Funerai	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cu 1 ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puer Specify:	to Rican, etc.)		ack, White, e	etc.
91915-0036	s 1 and 2 should be filed within 72 hours thatth and Mental Hygiene. Item 27 is marked other than "natural", othar traumatic event, the Modical Exe	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Giv	edent's Usual Docu e kind of work done DO NOT use retir	e durina most of wo	rking	16b. Kind of E		
21.5	d withi	mo	Elementary/Secondary (0-12) 8 th	College (1-4or 5+)	,,,,,	COOK	50)		DEC	THRANT	Tr
	be filed ital Hygi id other event, I	Bec	17. Father's Name (First, Middle, Last)			- COOR	18. Mother's Na	me (First, Middle	, Maiden Sumai		<u> </u>
Maryland	should be and Mental markad c	2		DLLAND				ARBARA C			
8 E	id 2 sho lth and 27 is m		19a. Informant's Name/Relationship (T) CHRISTINA R. R	_	T90. MAII GHTER)		at and Number or Ri	2020 00020			421
24	jes 1 and of Health if item 27 or othar tr		20a. Method of Disposition	2	0b. Place of Disp		HAMPLAIN	DR. API	B, BAL 20c. Location		
Baltimore &	nit. Page bartment o fortant: If injury or injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	1		N_CEMETER		19/04	_LANSDO	WNE. N	4D
A) , E	permit. Pag Department Important: I any injury o		21. Signature peral Service ricens	MARKE	1	2. Name and Addr			'UNERAL	HOME F	PA
	76		23a. Parti. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the	death. Do not er	ter the mode of dy	SILMOR STI	CEET BA	LTIMORE arrest,		21217 Approximate
	Physician		Immediate Cause (Final disease or condition	ne cause on rach line.							Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	sequence of):						10 1
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	nsequence of):			·			10+ hu
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	Consul	ye thy					_ 1 -	12 + 1
00	96 exercian ar	Exa	resulting in death) Last	Due to (as a co	sequence of):	0 1	-				
68760	tificate be executed g physician and as the burial-transit	edicai		1 fluitur	zgan	- faile	ur_				10 + lus
Division of Vital Records. P.O. Box 6		by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	cy		1	ate of deliver	ry Day Year
α.	s that the	y Ph	Part II. Other significant conditions co.	ntributing to death but no	t resulting in the t	ınderlying cause g	iven in Part I.	23e. Did	tobacco use con	tribute to the	e cause of death?
ord	v requires been sign should be						-	10	Yes 2□No	3 ☐ Proba	ably 4 Unknown
al Rec	: The law cate has b ; page 2 st	Completed						24a. Was auto perfe 1 Yes	psy ormed?	prior to com death?	sy findings available apletion of cause of
<u> </u>	sician: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	2 ER/Outpatie	-1 0CI DOA DI	26. Place of Dea	No.			
of	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea		III JU DOA	4 🗆 Nursing F		idence 6 Oth how injury occur		
Sign	uttendin death. ctor: Afi y the fur	catio	1 Natural 5 Pending 2 Accident investigation			M 1]Yes 2 □No				
Divi	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: Atter this certificate he completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (Sp	At home, farm, st pecify)	reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,
	e Hosp 24 hou E Funsi etely fil	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my ner: On the basis of examination and manner stated.	knowledge, dea mination and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	inner as stated	ted. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date signe	d (Month, D	lay, Year)
			14.11	ler		PI	7620		4/15,	104	
			30. Name a dia vess of pe in who co				MD 010	01			
11	Sta	te	DR. MAZTAR MASSRO 31. Date filed (Month, Day, Year)	UR, 22 S.	Greene S	Legalto	., MD 212	ΩŢ			
	Registr		APR 2 7 2004	MEMBER	1						

		•		State of Maryland / Depi r DWR, 0830, 04/27/04db				3154
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Robert E 4a. Facility Name (If not institution, give str	Hotem SR	4b. City, Town, or Location of Death	2. Date of Death Month	Day Yeer 3. 2 2004 4c. County of Deeth	Time of Death 3 3 3() AM
	Funeral Director		415 445951	y 2□F 7. Age (In yrs. last birthday)	Baltimore County If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye,	Baltimore 9. Birthplace Country) Nebra	(State or Foreign SKa
	he Maryland	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 10e. Street and Number	10c. City, Town or Lo	cimore County	100		nside City Limits ☐ Yes 2 🔀 No
	ath with t	Funeral Directo	1228 Halstead Rd.	W- P	21234		USA 14. Race - American Ir	ndian
920	ours after de rei', or item Examiner n	þ	11. Marital Status 1 □ Never Married ★★ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes À (Ž) No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:		Black, White, etc. Specify: White	idian,
Baltimore, Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland entment of Heath and Mental Hyglene. ortant: If tem 27 is marked other then "natural", or teme 23a or 28a-f ehow injury or other traumatic event, the Modical Extrainer must be notified at injury or other traumatic event, the Modical Extrainer must be notified at a.g.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12 yrs.	College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired) rchasing Agent		. Kind of Business/Industr ntage Book B	
yland ;	should be filed nd Mental Hyg marked othe umatic event,	e	17. Father's Name <i>(First, Middle, Last)</i> George William Hoter	n	Anna I	e (First, Middle, Maid rene Henl	ine	(0)
e, Mar	l and 2 sh tealth and im 27 is in her fraun		19a. Informant's Name/Relationship (Type Dorothy B. Hotem (W.	ife) 122		Baltimore,		
Itimor	permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is any injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Alicensee	Gardens	osition (Name of matory or other place) of Faith Cemetery 2. Name and Address of Facility assahn Funeral Ho	4~15~04 Ba		
	Physician /Medical Examiner	ılner	23a. Part 1. Enter the disease or complication of the state of the sta	ations that causes — e death. Do not en cause on each line.	/4Ul Belair Kd. Ba	Itimore, N	App Inte Ons	proximate prval Between set and Death 6 Mg J Mg
O. Box 68760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Completed by Physician/Medical Examiner	that initiated events resulting in death) Last		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
rds, P.O.	w requires that the state of the signed by should be detact	ed by Ph	Part II. Other significant conditions cont. DIABETES ASCV	nbuting to death but not resulting in the C		23e. Did tobacc	o use contribute to the ca	- V.
al Reco	i: The law re icate has bei r, page 2 sho			•		24a. Was an autopsy performed 1 Yes 2		
Division of Vital Records,	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing He	th (Check only one) ome 5 A Residence 28d. Describe how in	6 Other (Specify)	
Divis	itel or Atternis after dearral Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Ro ate)	ute Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical		cian: To the best of my knowledge, dea er: On the basis of examination and/or in and manner stated.		red at the time, date a		cause(s)
16.	1		> 12 Uluta	ルル npjeted cause of death (Item 23a) Cype	D17150)	4115/04	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Kaisen to	erman	ete	
100	Regist	rar	BDD 9 7 200/	Many see of	WORKS!			

			For Stata Registrar	State of Marylan	d / Depa <i>Cer</i>	irtment of H	ealth and Death		giene2004	13155
т	*	- T-85	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
П	°Physici /Medic		James Lee Heacoc	k				Month	Day Year Zoo	
. **	Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or	Location of De		4c. County of Dea	
a- ,			Saint Agnes Ho	ealth Come		Balter	nore.			N/A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hi		h 9. Bi	rthplace (State or Foreign
L	Director		212-42-3221	60	Yrs.			June 25		ryland
	and ¥ 1		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	, Town or Lo	cation				10d. Inside City Limits
	Manyl f aho	ō	MD M/A		-					1 X Yes 2 □ No
	the the the the the the the the the the	Director	MD N/A 10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	with Se or		1711 Harman Avenue				21230			States
	ms 2;	Funeral		Was Decedent Ever in U.		Vas Decedent of His Yes, specify Cubar		Specify Yes or No-		erican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. It has the marked other then "neturel", or Items 23s or 28e-f ahow other treumetic event, the Medical Examinational by notified at	by	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 No 12- If Yes, Give Year or Dates: 3-24-	2 9- 04	Yes, specify Cubar	n, Mexican, Pue Specify:	rto Rican, etc.)		ite, etc. White
2-0	72 ho	Completed	15. Decedent's Educat (Specify only highest grade of		16a. Deced	ent's Usual Occupa kind of work done d	tion	orkina	16b. Kind of Business	s/Industry
7	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)		orking .		
2	e filed w al Hygier other th	Cor	8		Tr	uck Drive			Transport	ation
<u>n</u>	be fill tal H d ott	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Surname)	
Z	2 should be f and Mental I Is markad of reumetic eva	2	George Joseph Heaco					y Lee La		·
Maryland	12 sh h and 7 Is n treun		19a. Informant's Name/Relationship (Type	ŕ					r, City or Town, State,	Zip Code)
	s 1 and 2 of Health item 27 othar tre		Mary Ann Knaub Fr 20a. Method of Disposition			Stormont Sition (Name of	Circle	Arbutus	MD 21227 20c. Location - City of	Town State
altimore,	ages of of h		1 X Burial 2 ☐ Cremation 3 ☐ Rem	.,	emetery, crem	ge Memori	- 4		,	,
Ħ.	t. Partmer		4 Donation 5 Other (Specify)	= Hea		_	4-2	24-2004	Elkridge, l	MD .
Bal	permit. Pages 1 Department of H Important: If its any injury or ot once.		1. Signatura Funeral Service Licensee	Dogues,	28/ 27	19 Hammor	ds Feri	ose Fune y Rd., L	ral Home of ansdowne, N	f Lansdowne D 21227
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death cause on each line.	. Do not ente	er the mode of dying	, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardiomy	math					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ						
	LAGIIIIIEI		Sequentially list conditions, b.	Sepsis_						weeks
	ad sit	Examine	Sequentially list conditions, b. actions. Enter Underlying Cause (Disease or injury	Due to for as a consequ	ience of):					
	cate be executed physician and the burial-transit	кап	that initiated events c.	Due to (or as a consequ	iance of):					
8760,	be ey ician buria			500 10 (0) 03 2 0013341	101100 01).					
87	physis the	dlcal	d							
9 X	death certific: e attending ph id for use as t	Physician/Me	IF FEMALE: 23c	If yes, outcome of pregna	ncv				23d. Date of de	liver
Вох	atter after I for u	clar	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			Month Month	Day Year
o.		lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
σ.		by Pł	Part II. Other significant conditions contri	outing to death but not resu	ilting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds		d b	Renal Failure					1 □ Y	es 2□No 3□P	robably 4 Hunknown
Vital Records,	> 40	Completed						24a. Was a	an 24b. Were a	utopsy findings available
Be	е с е	шc						autop: perfor	med? death?	utopsy findings available completion of cause of
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only or		3 2 No
	Physician: this certific al director,	To B	examiner?	pital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe	r.		ence 6 Other (Spe	acifu)
of			27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury Work			ow injury occurred	iony)
Division	를 는 중 글	ertification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? 'es 2 □ No			
Vis	l or Attenic	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho	me, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or R	ural Route Number,
	s after al Dire	Cert	4 - Homodo	building, etc. (Specify)			City of Yow	n, statej	
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physic	an: To the best of my know: On the basis of examinat	vledge, death	occurred at the time	e, date and place	e, and due to the c	ause(s) and manner a	s stated.
	tha H iin 24 tha F iplete	edical	one	and manner stated.	on and/or inv			uneu at the time, o	ate and place, and due	e to the cause(s)
	To 1 To 1	Σ	29b. Signature and title of certifier			29c. License	nu <i>m</i> ber	2	29d. Date signed (Mont	th, Day, Year)
•	6		Molemmed	MD		P176	10		April 20,2	5004
	0		30. Name and address of person who comp	eleted cause of death (Item	23a) (Type, F					
			Nareesa Mohammes	950 S.Ca	hon A	ve Bo	Imore	MD	21228	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure					
	Registr	ar	APR 2 7 2004	Mayer St.	And the	الع				

DHMH 17 Rev 1/2001

JAMES

HEACOCK,

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H			iene 200	4 13151
	Physici /Medic		1. Decedent's Name (First, Middle, Lass $\label{eq:Minimal} \text{Nimimal} G .$	Hendley			33	2. Date of Dea Month April	25, 200gar	3. Time of Death 14:20 м
	Examir		4a. Facility Name (If not institution, give Carroll Hospital	l Center		4b. City, Town, or Westmi	nster		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Security Number 577-12-7724 1 Usual Residence of Decedent	ex 7. Age □M 2∏ F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 919 9. Bir	thplace (State or Foreign
	a-f show	ctor	10a. State 10b. County MD Carro	1.1	10c. City, Town or Lo	cation esville				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	ath with the 23a or 28	rai Director	10e. Street and Number 2037 Stillwater	Road		10f. Zip Code 217	784	1	0g. Citizen of What C USA	
920	be filed within 72 hours after death with the Maryland stal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner roual be multied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N N If Yes, Give Year or Dates:	D I	Was Decedent of Hi I Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	te, etc.
Maryland 21215-0036	within 72 ho iene. r than "natui ihe Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired nistrativ	during most of wo ()		16b. Kind of Business Insurance	
/land	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Mas	To Be C	17. Father's Name (First, Middle, Last) Unknown	Lu	sby		18. Mother's Nar Lill:	me (First, Middle, i ian		known
	ges 1 and 2 should t of Health and Men if item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (7 Lt. Col., Ret. Al	ype. <i>Print</i>) (son bert J. He	ndley,III	2535 Sereni		Henderson,		
Baltimore,	permit. Pages 1 Department of H Important: If iten any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify)Entombrent	Loudon P	ark Mausc	1eum 4/2	29/04	20c. Location - City or Baltimore,	MD
Bal	Departing Important Import		21. Signature of Fyneral Service Licen Summer Summer Service Licen 23a. Part1. Enter the disease, or comp	. Hough		<u>Sykesvill</u>	e, MD 21	1784 (410	EL, PA (Bo	ex 195)
Į	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a.	c my	ounds	al m	faretion		Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, loading to manual at cause. Enter Underlying Cause, Disease or injury	1. ASC	consequence ():		l			25 yr
8760,	sate be executed physician and the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or as a	consequence of):					- J - F
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 19 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Q .	w requires that been signed b should be deta	þ	Part II. Other significant conditions or	ontributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tot	pacco use contribute to es 2 □ No 3 □ Po	o the cause of death?
Il Records,	ilcian: The law re certificate has ber rector, page 2 sho	Completed						24a. Was an autops perform	y prior to ned? death?	utopsy findings available completion of cause of
ion of Vital	ding Phys h. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatier 28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury Work	or: 4 ☐ Nursing H		e) ence 6 Other (Spe ew injury occurred	ocify)
Division	al or Atter s after dea il Director od in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying Ph. 2 Medical Exam	ysician: To the best of ninar: On the basis of and manner stat	examination and/or inv	occurred at the time vestigation, in my op	e, date and place pinion, death occu	and due to the caurred at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	With Common 1	Σ	29b. Signature and title of certifier	Midd	tetm M	D 29c. License			9d. Date signed (Mont	
	Y)		John W.	completed cause of de	ath (Item 23a) (Type,	88 Perle	o Roa	d, Wes	tminste	, MD21157
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 2004	32. Registra		south				

04-2672 Desmond	A. Hug	ghe	State of Maryland State of Maryland State of Maryland Registrar			•	9
	Physici	an	1. Decedent's Name (First, Middle, Last) DESMOND A. HUGHES	061	uncate of Death	2. Date of Death Month	Day Year 3. Time of Death
9	/Medic Examin		4a. Facility Name (If not institution, give street and number) Bon Secours Hospital		4b. City, Town, or Location of Death	April 18	8, 2004 1130 a ^M 4c. County of Death N/A
5	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. las	St birthday) 3 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Y	· · · · · · · · · · · · · · · · · · ·
	Maryland f ahow	tor		Town or Loc	tation		10d. Inside City Limits 1
į	3a or 28a	Il Director	10e. Street and Number 2009 WILHELM STREET		10f. Zip Code 21223	10g	i. Citizen of What Country?
98	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or Items 23a or 28a-f ahow raumatic event, the Medical Examble or could be c	y Funeral	11. Marital Status 1	If	Vas Decedent of Hispanic Origin? (Si Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 ☑ No Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - American Indian, Black, White, etc.
21215-0036	in 72 hours n netural;	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occupation kind of work done during most of won O NOT use retired)	king 16	ib. Kind of Business/Industry
1d 212	e filed with it Hygiene. other ther ont, It. M	Be Comp	Elementary/Secondary (0-12) Oth grade 17. Father's Name (Fist, Middle, Last)		COOK	e (First, Middle, Ma	FOOD SERVICE iden Sumame)
Maryland	hould by d Menta marked matic ev	ToE	Celvin Hughes 19a. Informant's Name/Rela Inship (Type, Print)	10h Mailin	JoAn		Awell
, Ma	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		JoAnne Hartwell	2000			timore, MD 21223
Baltimore,	Pages 1 ent of H nt: If iter ry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	ce of Dispos netery, crem	ition (Name of atory or other place) CMCTCX DH2		c. Location - City or Town, State AUTIMORE, MD
Balti	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra		21. Signature of Euneral Service Lecensee	22. V /	Name and Address of Facility	FUNERAL	
	N.		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	r the mode of dying, such as cardiac	or respiratory arrest	
	ny sicia n : /Medical Examiner		disease or condition resulting in death) Narcotic Intoxic Due to (or as a consequent		Associated With Seizu	re <i>Dis</i> order	
	7	ner	Sequentially list conditions, if any, leading to immediate sause. Enter United Pring Cause, (Disease or injury	ince of):			
760,	te be executed ysician and ie burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequer	nce of):			
P.O. Box 68	The respine or attended by the fundamental projection: The law requires that the death Certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	leath 3 □£	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P	equires mar en signed b ould be deta	þ	Part II. Other significant conditions contributing to death but not resulting	ing in the und	derlying cause given in Part I.		cco use contribute to the cause of death?
I Reco	ate has be page 2 sho	Completed				24a. Was an autopsy performed	
Division of Vital Records,	r this certific aral director,	To Be	27 Manner of Death 28a Date of Injuny 28	P/Outpatient	04	h (Check only one) me 5 Residence 28d. Describe how	e 6 □Other (Specify)
sion	leath. leath. tor: Afte the fune	catlor	1 Natural 5 Pending Townth, Day Year)	Injury	Work?	Unknown	
Divi	urs after d ral Direct illed in by	Certification:	Residence		1	Baltimore, N	
H	in 24 ho in 24 ho he Fune pletely fi	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowle 2 ☑ Medical Examiner: On the basis of examination and manner stated.	adge, death on and/or inve	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	Tot	Σ	29b. Signature and title of certifier		29c. License number OCME		Date signed (Month, Day, Year) April 19, 2004
			30. Name and address of person who completed cause of death (Item 23)	3a) (Type, P	111 Penn Stree		nore, Maryland 21201
A.	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature		all)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MHV			1 - For 1 - State Uppend Item#23a,	State of M. Part II,27	arylan Per M	d / Depa e ,G33), /	rtment	of He	ealth : Death	and M	lental Hy	giene 2	004	13158
	Physic		1. Decedent's Name (First, Middle, Last) Claude Herring		,						2. Date of De Month APRIL	aath Day	Yeer	3. Time of Death
ego .	/Medi Examir		4a. Fecility Name (If not institution, give s	treet and number)				TIMO	DRE C	CITY	MINI		nty of Death	
352	Funeral Director		5. Social Security Number UNK 6. Sex 1 (X) Usual Residence of Decedent	M 2□F 7. Ag	e (In yrs. I 49	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Dr July I	Year) 195	9. Birth	hplace (State or Foreign untry) UNK
. 4	a-f show	ctor	10a. State 10b. County MD		10c. City	, Town or Lo Bal	cation Ltimor	e						10d. Inside City Limits 11 Yes 2 □ No
	th with the M 23e or 28a-f ust be notifie	rai Director	10e. Street and Number 5901 Reisterstown	Road			10f. Zip (212	215			10g. Citizen o	USA	untry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I health and Mental Hygiene. I have 27 Is marked other then "naturel", or Itema 23e or 28a-f show other traumatic event, it a Marijical Exantinal must be notilified at	by Funeral	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Armed Forces? Tyes 2 If Yes, Give Year or Dates:		ınk	Vas Decede i Yes, speci Yes 2	y Cuban	spanic Or n, Mexical Specify:	n, Puerto	ecify Yes or No Rican, etc.)	В	lace - Amerilack, White	
Maryland 21215-0036	within 72 hours lene. then "naturel".	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) unk		5+)	(Give	lent's Usual kind of work DO NOT use	done du	uring mos	st of worki	_{ing} unk	16b. Kind of	Business/I	industry unk
yland 2	12 should be filed with n and Mental Hygiene 7 Is marked other the raumatic event, the	To Be Co	17. Father's Name (First, Middle, Last)			7	ι	ınk	18. Moth	er's Name	(First, Middle	, Maiden Sum	ame)	unk
	Health and temporary tem 27 is mother traum		19a. Informant's Name/Relationship (Type O • C • M • E •	e, Print)		111	Penn	Stre		Balti	more, N	1D 212	01	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 🖾 Other (Specify)	in state	Ce	lace of Disposemetery, crem	natory or oth	er place			Date	20c. Locatio	•	
Bal	Depar Impor eny ir		21. Signature Funeral Service License KOTHE I d. Signature W. Signature License W. Signature List only on shock, or heart failure. List only on	HXXV	actor	Da	TUTINO	re,	MD	2120	655 W.		nore	Street
8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and personnel director, page 2 should be detached for use as the burial-transit and personnel personnel.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Drisease or injury that initiated events resulting in death) Last	Atheros Due to (or as	a consequ a consequ	ic Carc								Onset and Death
P.O. Box 6	it the death certific by the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pre						Date of delivery	very Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con Renal Disease	tributing to death b	out not resu	alting in the ur	nderlying ca	use giver	n in Part I			obacco use co Yes 2 📉 No		the cause of death?
Division of Vital Records,	The law recate has be page 2 sho	Completed									24a. Was auto perfo 1 Yes		prior to co	topsy findings available completion of cause of
Vita	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 Ves 2 No	ospital: 1 ☐ Inpatie	ant Old	ER/Outpatien:	3 DOA	Othor			n (Check only one)		What (Case	4.1
ion of	ttending Physician: death. ctor: After this certific y the funeral director,	lie i	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		c. Injury : Work?	4 🔾 140	2	28d. Describe			ny)
Divis	ital or Atterns after de ral Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et			et, factory,	office		-	28f. Location (City or To		nber or Rui	ral Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	Medicai	29a. Certifier (Check only one) 1□ Certifying Phys	icien: To the best er: On the basis o and manner st	f examinat	wledge, death ion and/or inv	estigation, i	the time n my opi License	nion, dea	id place, a th occurre	and due to the ed at the time,	date and place	e, and due	to the cause(s)
	wit viit		29b. Signature and title of certifier 30. Name and address of person who co		2 /N leath (Item	23a) (Type, I			O C N	M E		APRIL		
	Sta		Tasha Z Greenber 31. Date filed (Month, Day, Year)	22. Registr	ar's Simat	ure					Balti	more, M	aryla	and 21201
	Registi	di	AFR ;	G / LUTT	Desi	yer h	T. 19	A Comment						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Day Lorraine G. Hammaker April 17. 2004 6:10 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Coffman Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 215-18-2780 Yrs. Director 87 Nov 28, 1916 | Maryland Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health end Mantel Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Washington Hagerstown 1 ☐ Yes 2√ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1304 Pensylvania Avenue 21742 Funerai USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Š Specify: White 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Campbell Fleigh Catharine Louise Rouskulp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bausman/daughter 13205 Sleepy Creek Lane Smithsburg, MD 21783 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of important: If any injury or 5 Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Funeral Service Licensee Ronald S. Wade Baltimore, MD 21201 Part 1. By ter the disease, or come lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) accident Imorela Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68769 been signed by the attanding physician and should be dateched for use as the burial-tra Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ ate has been signed Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 🗆 Yes 2 NO 1 Yes 2 No certificate : After this certifica e funeral director, p Be 25. Was cese referred to medical 26. Place of Death (Check only one) Certification: To 1 Yes 2 No 1 Inpatient Other: 4 Norsing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending deeth. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deeth To the Funeral Director: / complataly filled in by the f 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide the Hospital edicai 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 027898 perston, 40 21740 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) PHADCISCO ADDRADT 350 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

20

Hammaker,

State of Maryland / Department of Health and Mental Hygiene 2 State Registration ITEM #5 PER FH G830 4/27/04 JH Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician JEROME** HURWITZ APRIL 2004 24 5:40 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY ial Security Number 6. Sex 7. Age (In vrs. last birthday. Birthplace (State or Foreign Country) **Funeral** 2 🗆 F 218-08-3283 Director 87 12/18/1916 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov ust be notified at 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Itams 23a 116 W. UNIVERSITY PARKWAY APT. 832 21210 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. filed within 72 hours after 1 Never Married 2 Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 f Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "natural", other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) rthan Elementary/Secondary (0-12) **GROCER** F₀0D Pages 1 and 2 should be filed nent of Health and Mental Hygiant: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 NATHAN HURWITZ YETTA RUBIN 19b. Mailing Address (Street and Number or Charleute Number, (120906) flate, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BERNARD HURWITZ 3310 N. **WORLD BLVD** SILVER SPRING, MD LEISURE 20a. Nethod of Disposition

1 Disposition

3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stets permit. Pages 1 Department of H Important: If Ite any injury or ot once. SHAAREI ZION * 4 ☐ Donation 5 ☐ Other (Specify) 04/26/2004 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN RD PIKESVILLE MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician ATHEROSCLEROTIC** CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit **GANGRENE OF LEG** that initiated events resulting in death) Last Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 2 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification; After 1 Natural 5 Pending investigation death 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hitricia 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) $r/\omega d$ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Ragistrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dorothy E. Jordan April 2004 1:45 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Cranberry Cottage Assisted Living Glen Burnie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 1 X F 93 Director 212 07 6735 1911 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits r then "naturel", or Items 23a or 28e-f show the Medicul Exerciner must be notified at 1 ☐ Yes 2 XNo Maryland Anne Arundel Glen Burnie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 U.S. 14 Proctor Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "naturel", or Itel 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Machine Operator J.L. Clark 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny injury or other treumetic event size. Milton Jordan Mary Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5943 Linthicum Lane Mary M. Shipley / Niece Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery | 4/29/2004 | Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signal re if Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part1. Enter the disease, creson shock, or heart failure. List only hplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Onset and D Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Duerto (or as a consequence of): Examiner Hensia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a consequence of): the attending physicien and thed for use as the burial-transit unen The law requires that the death certificate be executed resulting in death) Last Due to (or as wonsequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? page 2 should be detached tor Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 10 No 1□ Yes 1 ☐ Yes 2 110 To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: Atter this certilics completely tilled in by the tuneral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assister Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ØOther (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Man of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 104 20 death (Jem 23a) (Type, Brint) Lol 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 APR 2 Registrar 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Johnston Alexander Joseph <u>5:</u>16₽[™] April 24, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 209-28-3241 65 June 22,1938 Pittsburg, PA Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ent: If Item 27 is marked other than "naturel; or Items 23a or 28e-f ehow ury or other teamstic event, Its Madical Examine, must be notified as ury or other teamstic event, Its Madical Examine. 1 XYes 2 No MD Director Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3308 Moylan Drive 20715 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 TYPes 2 □ No If Yes, Give Year or Dates: 155-158 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No Specify: White altimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operations Manager 12 Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marion Flack ပ William Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor J. Johnston/ Wife 3308 Moylan Drive Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Himportent: If Ite eny injury or ot once. 1 X Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 4/29/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD permit. 22. Name and Address of Facility 21. Signature of Furféral Service License Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Myocardia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed 18mari physicien as s the burial-t P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 23e. Did tobaccouse contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ has been signed 2 should b 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate ha 25. Was case referred to predical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 anpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide within 24 hours 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rotoro 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AURIA UBRANO DRIVE SUITE 300 128 NATORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 7 2004 Registrar

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	Ore, Maryland Z1Z1 jes 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other than '	-	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailir	ng Address (Street					Zip Code)
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S. C	The Cords, F.O. BOX of The law requires that the death certivate has been signed by the attending page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	at time of death	5 ∟	Other (specify)					
TEPHEN	IS, F.	by Ph	Part II. Other significant conditions	contributing to death	but not resulting	in the u	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute t	the cause of death?
16	cords, wrequires t been signe should be or		PERIPHERAL	VASCUL	AR DI	SER	SE		_ 1 🗆	Yes 2	!□No 3□P	robably Unknown
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State of Maryland / Department of Health and Mental Hygiene 0 0 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Eduard Robert 12:45 PM 04 20 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 201 Minta Court Linthicum Anne Arundel 5. Social Security Number 6. Sex 1 AM 2 F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 220-03-2984 83 Feb. Director 1921 MD Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Weddeat Examinal mankles inclined at 10a. State 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 No Linthicum Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Minta Court 21090 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give 1941-45 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician **RCA** 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ August Kelch Wilheminia Raulins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Verna Kelch / wife 201 Minta Court, Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans April 23,2004 Crownsville, MD 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Finieral Service Licenses Second Avenue S.W., Glen Burnie, MD 21061 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Coronary Arten /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cerebro Vascular Due to for as a consequence of Examiner buriaj-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physicien hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an certificate has funeral director, page 2 autopsy 1 Yes 2 ₽ No Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 051811 Inm 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ad Baltinon Thomas N. Nolling 1120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Sina Apri 2004 nia /Medical 4c. County of Death 4b. City, Town, or Location of Death VIf not institu Examiner altimore 9. Birthplace (State or Foreign Scountry) If Under 1 Months If Under 24 Hrs Date of Birth cial Security Number 6 Sex **Funeral** Min. Davs Hours 1 □ M Director Residence of Decedent the Maryland City, Town or Location
DUTIMORE 10d. Inside City Limits 10a. State 10b. County "natural", or items 23s or 28s-f show 1 Tes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code USA 1229 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc., 1 Never Married 2 Married 1 Yes 2 No Baltimore. Maryland 21215-0036 Yes, Give Specify 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) conflary (0-12) College (1-4or 5+) Elementar urse 17. Father's Name (First, Middle, Middle, Maiden Sumame) Be 2 Number, City or Town, e/Relationship (Type, Print) 20a. Method of Disposition 20c. Location -Jarrison Forest 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once: Other (Specify) * 4 Donation 21. Signature of ton face Ealto, mo alaas e direase or complications that caused the death. art failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such shock, or Immediate Fair e (Final disease or Adition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequen Records, P.O. Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month detached for in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed to be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 3 Probably 4 | Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? < h 2 No 2 No 1 Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be examiner? Hospital: Other 5 Residence 6 Other (Specify) 2 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No death. investigation within 24 hours after death To the Funeral Director; completely filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day,

7 2004

AFR 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04 Day 25 Year 4 8:17 A M Mary R. Keimig 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore City 3026 Fleetwood Ave | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | September 6, 1930 | Maryland | Manyland | Min. | September 6, 1930 | Maryland | 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🙀 F 73 212-28-4224 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits N/A 1 Yos 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3026 Fleetwood Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕽 No Specify: Specify White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Bank Officer Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Keimig Helen Rose Hinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. Crostic/Nephew 905 Coteswood Circle Cockeysville Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Gardens of Faith 4/29/04 Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Baltimore Maryland 21214 Inc. 5305 Harford Road Leonard J. Ruck, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IMM. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
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Physician /Medical Examiner P.O. Box 687

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

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Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

id 2 should be filed within 72 hours after death with the Marylan lih and Mental Hygiene. 27 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

es 1 and 2 should b of Health and Ments I Item 27 is marked r other traumatic e

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Examiner attending physician and for use as the burial-transit Completed by Physician/Medical signed by the a Be ٥ his. Medical Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records,

within 24 hours after death.	To the Funeral Director: After t	completely filled in by the funera	
1		()

State Registrar

29b. Signature and title of certifier Maria mo

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Morth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ran

31. Date filed (Month, Day, Year) APR 2 7 2004

29a. Certifier

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene20013169 State
RegistreAMEND ITEN #26 PER VERB C830 4/27/04Contificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 22, Day 2004 Year **Physician** 5:30 P. M Henry Knell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Johns Hopkins Bayview Medical Ctr. Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 83 yrs 8. Date of Birth Month, Day, year) 5. Social Security Number 6. Sex **Funeral** 212 01 6594 1ĂM 2□ F Days Hours Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Baltimore Raspeburg 1 ☐ Yes 2 No MD Director 10g. Citizen of What Country? USA 10e. Street and Number 5000 Anntana Avenue 10f. Zip Code 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? TXXYes 2 ☐ No If Yes, Give WIII Year or Dates WIII 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after if Hygiene. other than *natural', or Ite 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2€No Specify: δ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bendix Production Conductor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Itsm 27 is marked oth any injury or other treumatic event Be Carrie Freifzu John E. Knell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1708\ Boggs\ Rd.$ Forest Hill MD 2105019a. Informant's Name/Relationship (Type, Print) Henry James Knell Jr. SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4/26/2004 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicer see 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical ar coma - Gastro intes Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing indepth). Examiner Diva to for as a consequence off The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the all 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 (No 3 Probably 4 □Unknown 1 ☐ Yes peed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 certificate 1 Yes 2 No or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \) Nursing Home \(\triangle \) Simple ence \(6 \) Other \(\triangle \) Other \((Specify) \) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 3 MD 21093 3 SUMAN VEP SITE 107 (MORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

State of Maryland / Department of Health and Mental Hygien [] [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Viola Lea Lester Apri 2004 6:04 P /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 3500 Honeysuckle Lane Middle River 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, NOV 8, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 X F 215-46-5054 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intit if tiem 27 is marked other then "netural; or items 23e or 28e-f ehow mix; if tiem 27 is marked other then "netural; or items 23e or 28e-f ehow my or other traumatic event, the Medical Exercities must be notified at my or other traumatic event, the Medical Exercities must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2√ No Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3500 Honeysuckle Lane 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Della Marie Benton Jeffrey O. Lester, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7207 Kennebunk Road Jeffrey O. Lester, Jr./Brother Windsor Mill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Lake View Memorial Park 4-29-04 Sykesville, MD 21. Signature of Fureral Service licenses \(\) C

Dawn F. McDonald MacNabbafusefally Home, P.A. Nonald 301 Frederick Road Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** in FARCTION MUDCAMIAL /Medical Due to (or as a consequence of): **Examiner** Morbid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 1 ☐ Yes 2.☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 151116 April 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.Mt. Royal AH BAITIMON ME 21217 JoAnnek. MO 1501 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 2 7 2004

ORIGINAL

	04-266	1	1 - For State Registrar	State of	Marylar	nd / Depa	artment	t of H	ealth a	and M	lental Hy	giene	2004	13171
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	/Medic			Michael		d Lane					Apri		2004 ^a r	2323 PM
	Examir	er	4a. Facility Name (If not institution Route 32 East		,	Chara Da			Location of			4c. (County of Death	
			5. Social Security Number		. Age (In yrs.		If Under		If Under		9 Date of Bir	th	Howard	olana (State of Foreign
и	Funeral Director		215 92 9025	6. Sex 1 M 2 F	40	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da May 3,	19, Year)	Coul	place (State or Foreign ntry) q ini a
			Usual Residence of Decedent					1			ray 5,	1303	VIL	gilla
	Maryland	<u>. </u>	10a. State 10b. County	7,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	ty, Town or Lo								10d. Inside City Limits
	88a-f	Director	-	Arundel	G	len Bu								1 □ Yes 2ĀŪ No
	a or 2	D.	10e. Street and Number 1090 Cayer Dr	ive			10f. Zip	Code 2106	.1			_	en of What Coul	ntry?
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re,	is 1 and of Health itam 27 other tr		20a. Method of Disposition			Diace of Dispo cemetery, cren	sition (Nam	e of	1		ate		ation - City or To	
E 0	Pages nent of nt: If ii		1 ☐ Burial 2 🏧 Cremation 4 ☐ Donation 5 ☐ Other (S			yview (1/22/	2004	Balti	imore, M	faryland
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service	Licensee	neller	40	. Name and	Addres tchi	s of Facilit	Goi ghwa	nce Fun	eral	Service	-
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	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of):	- 1(-				0	(
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Вох	death certific e attending p d for use as i	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregna h 2 🗆 Feta		lEctopic pre	gnancy				23	d. Date of delive	*
0.		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnar 9□ Unknov	nt at time of d	eath 5	Other (spe	cify)					Month	Day Year
م	a o	Ph	Part II. Other significant condition	ons contributing to dea	th hut not res	ulting in the ur	derlying ca	use aive	n in Part I		23a Did to	nhacen usi	a contribute to th	ne cause of death?
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tal	ilcian: Th certificate rector, pag	Be Co	25. Was case referred to medical						26 Place	of Death	Check onl o	2 No	Yes	2□ No
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Sio	Attending r death. sctor: After by the fune	catio	2 Accident investig	gation 9-17	-04	11:23	Рм	1 🗆 Y		10 1	receased	trui	ik enla	arhment
Division	or Att	Certification:	3 Suicide 6 Could i 4 Homicide determ	inad 289. Place of	f Injury - At ho , etc. <i>(Specif</i>)	ome, farm, stre	et, factory,	office		- 17	City or Tou		Number of Rura	Route rum er,
	Hospital	ဦ	29a. Certifier 1 ☐ Certifvin	a Dhuaisian Tartha b	n	20.CX					great Sta	rDn	Howard	Co PTD
	To the Hospital or Attending Physician: within 24 hours after deals. To tha Funaral Director: After this certific completely filled in by the funeral director.	edical		g Physician: To the b Examiner: On the bas and manne	is of examina	wiedge, death tion and/or inv	occurred a restigation, i	t the time in my opi	e, date and nion, deat	f place, a h occurre	and due to the ded at the time, of	date and p	nd manner as st lace, and due to	ated. the cause(s)
	To the within 2 To the complet	M	29b. Signatur and itle if certified	1 1	10		29c.	License	number			29d. Date	signed (Month, I	Day, Year)
	6-		EXACY.	ANX 1	V			O.C.1	M.E			April	18, 2004	
	9		30. Name and address of person	who completed cause	of death (Item			nn St	reet,	Balti	morre, Ma	ryland	21201	
	Sta Registr		31. Date filed (Month, Day, Year)	2 7 2004 D	jistrar's Signa	ture	A P	ا هم						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of iv	iaiyianu /		tificate					Reg. No.	2004	-13172	
	Physici /Medio		1. Decedent's Name (First, Middle, La		Langf	ord,	Jr.				2. Date of D Month	Peath Apr 20,	2004 Year	3. Time of Death 4:46 Pm. M	
	Examir		4a. Facility Name (If not institution, given University C	ve street and number of Maryland Me		m	4b. City, To	wn, or		of Death Baltim	ore	4c.	County of De	eth N/A	
	Funeral Director			Sex 7. A 1 🗶 M 2 🗆 F	ige (In yrs. last b	oirthday) Yrs.	If Under 1 Months D		If Under Hours	24 Hrs. Min.	8. Date of E (Month, L Oct 1	irth Day, Year) 7, 1959	9. Bi	rthplace (State or Foreign country) Maryland	
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland	I/A	10c. City, To	wn or Lo	cation	Ball	timore		•			10d. Inside City Limits X 1 ☐ Yes 2 ☐ No	
	h with the 13a or 28e at be noti	Funeral Director	10e. Street and Number 3308 Glen Ave.				10f. Zip Co	ode	2121	5		10g. Citi	zen of What C		
136	be filed within 72 hours after death with the Maryland Ital Hygiene. ud other than "natural", or Items 23s or 28e-f show event, the Madical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 X If Yes, Give Year or Dates	:?] No		Was Deceder if Yes, specify				ecify Yes or N Rican, etc.)	10-	14. Race - Am Black, Wh Specify:		
9500-61212	within 72 housene.	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation rade completed)		a. Deced (Give life. I	dent's Usual (kind of work of DO NOT use	done di retired)	tion uring mos	t of work	ing	16b. Ki	nd of Business	s/Industry ruction	
Maryland 2	nd 2 should be lith and Mentai 27 is marked o r treumatic eve	To Be C	17. Father's Name (First, Middle, Las		18. Mother's Name (First, Middle, Maiden Sumame) Beatrice Clark										
			19a. Informant's Name/Relationship Beatrice Clark Mother	(Type, Print)						a <i>i Route Nu</i> m laryland 2		r Town, State,	Zip Code)		
Baltimore,	Pages 1 ar nent of Hea ant: If Item i		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Control		20b. Place cemel	of Dispo ery, cren	sition (Name matory or othe Mt. Zion)		Date 04/26/04		cation - City o andsdowr	r Town, State n , Maryland	
Balt	permit. Page Department Important: If any injury or sncs.		21. Signature of Fund al Service Lice	22. Name and Address of Facility Estep Brothers Funeral 1300 Eutaw Place Balti						al Home I altimore, I	P.A. VID 212	17			
State of	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each a. PC	line.	eu	er the mode o	2		cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
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68760,	tificate be executed g physician and as the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequenc	e of):									
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on of	iding Phys th. After this funeral di	tlon; To	1 Yes 2 No Hospital: 1 □ Inpatient 2 ■ ER/Outpatient 3 □ DOA Uther: 4 □								sing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				

To the Hospitel or Attend within 24 hours after death To the Funerel Director: / completely filled in by the f

m

State

Registrar

31. Date filed (Month, Day, Year) MAY 1 0 2004

29b. Signature and title of certifier

3 🗌 Suicide

29a. Certifier (Check only one)

4 Homicide

6 Could not be determined

Greene St Baltimore 32. Registrar's Signature

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

park

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

MD

D00054947

21201

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

18. Mother's Name (First, Middle, Assign Sumane) 19. Malling Address (Stered and Aumber or Rural Route Number, City or Town, State, Zp Code) 19. Malling Address (Stered and Aumber or Rural Route Number, City or Town, State, Zp Code) 20. Method of Disposition 19. Malling Address (Stered and Aumber or Rural Route Number, City or Town, State, Zp Code) 21. Zabeth Wychgram/Sister 20. Place of Disposition (Name or Camelety, crematory or other place) 21. Signature of Furgrey Bernotal Language 22. Name and Address (Stered and Aumber or Rural Route Number, City or Town, State 22. Name and Address (Stered and Aumber or Rural Route Number, City or Town, State 22. Name and Address of Facility 22. Signature of Furgrey Bernotal Language 22. Name and Address of Facility 22. Signature of Furgrey Bernotal Language 22. Name and Address of Facility 22. Signature of Furgrey Bernotal Language 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23. Nam				5	State of Maryland	I / Departme	ent of Health and			4	3173
Security Security		-		Decedent's Name (First, Middle, Last)		Certifica	ile oi Dealii			3. Ti	me of Deeth
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Compared Compared	-			4e. Facility Name (If not institution, give str	eet and number)		4b. City, Town, o				VIOCIT
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The state of the s		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la.	Month		n. (Month, Day,	Year) 9. E	Birthplace (S	itate or Foreign
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The part of the pa		land			10c. City,	Town or Location				10d. Insi	ide City Limits
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Physician (Medical Examiner) Part Continue Conti	D	20.5 2 3		mans/					Darcimore	BUIC	
The color of the				23a. Part . Enter the disease, or complication or heart failure. List only one	tions that caused the death. cause on each line.	Do not enter the m	ode of dying, such es cardi	ac or respiratory arre	est,	Interve	el Between
Sequentially list conditions, designed or condition good to the cause of death? Sequentially list conditions, designed or conditions contributing to death but not resulting in the underlying cause given in Pert I.	1			Immediate Course (Final	(, 91		4			Onset	and Death
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ROBERT 21Berty MD. 3,08 Back ST Ballo Und 21224	•			30. Name and address of person who comm	pleted cause of death (Item 2	23a) (Type, Print)	raiyey		// //		
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DHMH 16 Rev 6/95

			1 - For State Registrar	State of M	laryland /	/ Depa	artment of H	lealth a Death	and Me		gienę Reg. No.	2004	131	74
	Physici /Medic		1. Decedent's Name (First, Middle, L Mar	garet Mary	Meals					APRIL		200 ^{¥ear}	3. Time of D 5:00	
	Examir		4a. Facility Name (If not institution, g	and the second second			4b. City, Town, or	r Location of	of Death		4c.	County of De	ath	
			Montclaire Manor 5. Social Security Number 6.		Living ge (In yrs. last	hirthday	Fulto	On If Under:	24 Hrs G	Date of Bir		Howard	irthology /Ctoto or I	Forming
	Funeral Director		212-07-4724	1□ M 2□xF	93	Yrs.	Months Days	Hours		MAY 19	Year	10 Ma	rthplace (State or I Country) Ty Land	-oreign
	p.		Usual Residence of Decedent											
	anylau ahow	2	10a. State 10b. County		10c. City, T		cation						10d. Inside City	
	the M	ecto	Maryland Worcest	.er	Berl	ın	10f. Zip Code				10a Citi	zen of What C	1 Tes 2	X
	3a or	Funeral Directo	94 Martinique Ci	rcle			21811				USA	2011 01 44112(0	outility?	
	death ms 2:	nera	11. Marital Status	12. Was Decedent		13.	Was Decedent of Hi	ispanic Orig	gin? (Speci	fy Yes or No			encan Indian,	
ထ္	after or Ite	/Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give		1	lf Yes, specify Cuba 1 □ Yes 257 N <i>o</i>	in, mexican Specify:	1, Риело Ні	can, etc.)		Black, Wh Specify:		
Ö	hours ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:									White	
5	in 72	olete	15. Decedent's (Specify only highest g	rade completed)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	durina most	t of working		16b. Kii	nd of Busines	s/Industry	
21215-0036	filed within 72 hours after death with the Maryland Hygiene, ther than "natural", or Items 23s or 28s-f show the than Medical Examinat must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or		Manag	ger				Bak	ery		
D D		Be (17. Father's Name (First, Middle, Las					_	,	First, Middle,				
Maryland	should be find Mental I	2	William George							Margar				
<u>a</u>	12 and 12		19a. Informant's Name/Relationship Mary Jane Mitche				ng Address (Street a			_				
<u>ē</u>	Head Head the		20a. Method of Disposition		20b. Place	of Dispo	artinique sition (Name of matory or other place		Dat	Berlin	,	2181		
altimore,			1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State cify)			ematory I	1	4-27-0	04	Ra1	timore	≅ MD	
alti	permit. Pag Department Important: I eny injury o		21. Signature of Faneral Service Lic	PMC Om	ald	22	. Name and Addres	s of Facility	у		~	CIMOLC	, 1.10	
m	89 8 8	0 10	Dawn F. McI	onald	we	}	Cremation 199 Frede	rick	ety o Road	Ba i t	imor	e, MD	21228	
Y.			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause of each I	ine.			g, such as	cardiac or r	espiratory ar	rest,		Approximate Interval Betwe Onset and Dej	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. + 1			rs D	45l	a)	2			one 11	۲.
t,	Examiner			Due to (or as	a consequenc	ce of):								
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	ecuted Ind transi	Examln	Cause (Disease or injury that initiated events resulting in death) Last	c										
760,	death certificate be executed e attending physician and of for use as the burial-transit	cal Ex	resulting in death) Last	Due to (or as	a consequent	ce of):								
289	ficate physis the			d .										
XOX	leath certifical attending phy I for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			7°-4i				2	3d. Date of de	livery	
		Physician/Med	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4□ Pregnant a			Ectopic pregnancy Other (specify)					Month	Day Yea	ar
J.	res that the de igned by the a be detached f	Phy	9 ☐ Unknowfn V Part II. Other significant conditions	contributing to death t	out not reculting	a in the w	darhina couca aus	a in Bart I		22a Did to	bassa III	a contributo t	o the cause of dea	the?
ďs,	requires that the peen signed by th hould be detache	d by	Tary in Suist organization of the suit of	contributing to abalif a	out not resulting	g iii tile di	idenying cause give	minranti.			es 2[robably 4 DUnk	
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r	9 B	ошо								autop perfor 1 Yes		prior to death?	completion of caus	
	ysician: The is certificate director, pag	BeC	25. Was case referred to medical examiner?					26. Place	of Death (C	Check only o	/	1016	Acric L	- 6
0	this la	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie			t 3□ DOA Othe	or: 4 □ Nur		5 🗆 Resid		ther (Spe	ocify)	C
	ing After	:lou:	27. Manner of Death 1 △Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year) 28t	o. Time of Injury	28c. Injury Work	?		d. Describe h	ow injury	occurred		0
Division	al or Attending P after death. I Director: After I d in by the funera	ficat	2 Accident investigati 3 Suicide 6 Could not determine	be an Place of Ini	iury - At home.	farm, str	eet, factory, office	/es 2□N		Location (5	treet and	Number or A	ural Route Numbe	r
2	al or / s after of Dire	Certification:	4 Homicide	building, et	ic. (Specify)		,			City or Tow	n, State)			
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical (29a. Certifier	Physicien: To the best	of my knowled	dge, death	occurred at the tim	e, date and	d place, and	due to the c	ause(s)	and manner a	s stated.	
	the H	Medi	one) 29b. Signature ap ## title of certifier	and manner st	ated.		29c. License							
	F 3 4 8		> King Ill	1 hor			1		712	60	Y	Jugited (MOI)	th, Day, Year)	
	V		30. Name and address of person who	completed cause of a	death (Item 23a	a) (Type.	Print)		110)	4		X	U4	
	,		Lisa Huber	MED 1		Sicr	,	New	1. W.	oral St	ack	MID	2116	23
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	Registr	ar	APR 2 7 2004	And The Park	14	Top	V Lat Visit							

ROBER	T MANK		51			N1 1 . 4		_				
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AK	(G		Registrar Decedent's Name (First, Middle	, Last)		061	inicate of	Death	2. Date of D	Reg. No.		3. Time of Death
	Physici			Robert C	. Mank	Jr.			April	23, 20	Year O4	2:00 P M
	/Medic Examin		4a. Facility Name (If not institution	give street and numi	ber)		4b. City, Town,	or Location of Death	-		ty of Death	2.00 1
6			1000 block West	Baltimore	Stree	t	Baltimo	ore		I	N/A	
352	Funeral Director		5. Social Security Number 217 72 5762 Usuel Residence of Decedent	6. Sex 7 1 25 M 2□F	. Age (In yrs. 46	last birthday) Yrs.	If Under 1 Year Months Days		Jan.	oay, Year) 5, 1958	Cour	place (State or Foreign htry) Yland
17	ath with the Maryland 23e or 28e-f show ust be notified at	tor	10a. State 10b. County	Arundel		y, Town or Lo					1	10d. Inside City Limits 1 ☐ Yes 2 No
		irec	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	death with the	al D	760 Willowby	Run			21	122		U.S	5.	
	9 2 3	Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U.	S. 13.	Vas Decedent of Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No Rican, etc.)	lo- 14. Ra Bi	ace - Americ	
Baltimore, Maryland 21215-0036	10 0	by	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		I∏Yes 2. No			Spec		
15-		Completed	15. Decedent (Specify only highes			(Give	lent's Usual Occu kind of work done 30 NOT use retire	e during most of wor	king	16b. Kind of	Business/In	dustry
12	e filed within at Hygiene. I other then "vent, Ine Mac	dwo	Elementary/Secondary (0-12)	College (1-			ist	00)		Paint	ting	
5	Hygie other	a l	17. Father's Name (First, Middle, I	4				18. Mother's Nan	ne (First, Middl			
ılar.	ould be Mental Marked o	To B	Rober	t G. Mank	Sr.			Mai	ry Larn	er		
lary	2 sho and N Is me	·	19a. Informant's Name/Relationsh	nip (Type, Print)				et and Number or Ru	ral Route Num	ber, City or Tow	n, State, Zip	Code)
≥	and and marking markin		David Mank /	Brother	1001 0		Villowby			Maryla		
ore	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 Is marked othe or other traumatic event,		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 Removal from S	late		sition (Name of natory or other pla		Date	20c. Location		
Ë	t. Partmen		'4 □ Donation 5 □ Other (Sp		Gle		en Mem.					, Maryland
Bal	permit. Page Department. Importent: If eny injury o		21. Signature of Funeral Service I	.icensee	1		Name and Addr	hie Highw	once Fu	neral S	ervice	e, P.A. yland 21225
	E a		23 art 1. Enter the disease or	complications that car	used the deat						, Mar	Approximate
	-		232 art1. Enter the disease or shock, or heart failure. List Immediate Cause (Final						,			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		n and		1 Intoxi	cation			-	
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IXY	ecuted and -transit	caminer	Cause (Disease or injury that initiated events resulting in death) Last	c								
90,		ω̂.	resulting in death) cast	Due to (o	r as a conseq	uence of):						
87	icate be ex physician s the burial	dlce		d								
Box 68760,	.Ξ Ονα	Physician/Medical	IF FEMALE:	23c. If yes, outcome	ome of pregna	incy				23d D	ate of delive	anv.
Bo	death cert attendin I for use	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live bir	th 2 ☐ Fete nt at time of d	death 3	Ectopic pregnand Other (specify) _	cy			fonth	Day Year
P.O.	at the de by the a	hysi	9 Unknown	9□Unknov	vn				4			
۳,	res that igned to be det	by P	Part II. Other significant condition	ns contributing to dea	ith but not res	ulting in the ur	nderlying cause g	iven in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
Division of Vital Records,	w require been sig should b	ted t							1	Yes 2 No	3 ☐ Prob	pably 4 Unknown
ecc	e law re has be je 2 sho	Completed							24a. Wa	s an 24b	. Were auto	psy findings available mpletion of cause of
= R		Corr							1 Yes	tormed?	death?	2 No
/ita	or Attending Physicien: ufer death. Director: After this certifici in by the funeral director,	Be	25. Was case referred to medical examiner?	Manutali				26. Place of Dea	th (Check only	one)		
of	Physi this c	- To	1 XXes 2 ☐ No 27. Manner of Death	Hospital: 1 🔲 In	patient 2	ER/Outpatien 28b. Time of	COLLOCA			idence 6/50		w At scene
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isi	Attendideath.	fica	3 Suicide 6 Could r	1, 23, 0		1:54 ome, farm, str	eet, factory, office				ያትያ የተ ያገ ዛም	l Route Number
ρį	al or / s after Il Dire	Certi	4 Homicide determine	Found	g, etc. (Specify in vac	ant bu	ilding		St. City of To	Itimore	, Md	Route Number Balti
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 Certifyin (Check only one)	g Physician: To the b Examiner: On the bas and manne	sis of examina	wledge, death tion and/or inv	occurred at the trestigation, in my	time, date and place opinion, death occu	, and due to the rred at the time	e cause(s) and n , date and place	nanner as st	Rated. o the cause(s)
	To the within 3 To the comple	M	29b. Signature and title of certifier	\	\bigcirc	00		se number		29d. Date sign	ed (Month,	Dey, Year)
			Tatul	umil	2- Ke	Klel	S	O.C.M.E.		April 2	24, 20	004
			30. Name and address of person	who completed cause	of death (Item	23a) (Type.		C1 :	D. 71		(m==-7	nd 21201
	*		31. Date filed (Month, Day, Year)	10 N.CA	gistrar's Signa	ICK	CALL PE	enn Street	, Balt:	unore, M	атАта	INT STSOT
	Sta Registi		(0)	PR 2 7 2004	gioriai o orgila		does !	40 3				
DH	IMH 17 Rev 1/2		Ar	N 6 (ZUU4	132,109	1932 A	The state of the s					

Physic	ian	1. Decedent's Name (First, Middle, Leroy Holtzma	,				2. Date of Dea Month 4	Day	3. Time of Death
/Medi		4a. Facility Name (If not institution,			4h City Town	or Location of Dea		4c. County of	304
Exami	ier	North Arundel I		EAGROVE RD				Anne A	
Funeral		5. Social Security Number 6		yrs. last birthday)	If Under 1 Yea Months Days				Birthplace (State or Fore Country)
irector		214-18-7338 Usual Residence of Decedent	IXIM 201F	81 Yrs.			9-17-19	22	MD MD
a-f show	ctor	10a. State 10b. County	rundel	City, Town or Lo	cation Burnie				10d. Inside City Lin 1 ☐ Yes 2X
23e or 28 at te no	Funeral Director	10e. Street and Number 717 Seagrove Ro	ad		10f. Zip Code	21060	1	0g. Citizen of W	hat Country?
Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or items 23s or 28s-f show ery injury or other traumatic event, the Madical Examiner must be notified at ance.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	411	1942-	Was Decedent of f Yes, specify Cu		Specify Yes or No- rto Rican, etc.)		- American Indian, c, White, etc. white
*netural; or items 23a or 28a-f ehow	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occu	e during most of we	orking	16b. Kind of Bus	siness/Industry
than than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retir Steamfi	•		Commerci	ial Plumbing
and Mental Hygi marked other umatic event,	To Be Co	17. Father's Name (First, Middle, La Charles H. Ma	•			18. Mother's Na	me (First, Middle, I)
h and h		19a. Informant's Name/Relationship		111			ural Route Number		State, Zip Code)
nent of Health int: If item 27 iry or other tr		Mr. Edgar F. Man 20a. Method of Disposition		b. Place of Dispos	sition (Name of	1			City or Town, State
ent of nt: If it ry or o		1 Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		loly Cros	natory or other pl ss Cemete		/2004 E		, MD
Depertment Important: I eny injury o		21. Signature of Funeral Service Lin	censee	(0/357 1	. Name and Add	ress of Facility Sa	ingleton l len Burnio	Funeral	Home
hysicien and Medical the prival-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, frank, leading to a mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con	sequence of):	ndial	Infanc	110-		Onset and Death
attending p for use as	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	Fetal death 3 🗌	Ectopic pregnant	су		23d. Date Mont	of delivery
ed by the detached	ysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	or death 5 -	(Specify)				
sign d be	þ	Part II. Other significant condition	s contributing to death but not	resulting in the un	nderlying cause g	iven in Part I.	23e. Did tob 1 □ Ye		oute to the cause of death?
S C/	Completed	angestie &	unt faile	ye-			24a. Was ar autops perform 1 Yes 2	y pri ned? de	ere autopsy findings availation to completion of cause lath? Yes 2 No
certificate ector, pag	Be	25. Was case referred to medical examiner?	Manaitali		In		ath (Check only on	θ)	
rthis o	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigal	28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Inju		Home Ex side 28d. Describe ho		
uth. :: After e funer	‡C	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		At home, farm, stre ecify)	eet, factory, office		28f. Location (Str. City or Town		r or Rural Route Number,
s after death. el Director: After ed in by the fune	Certi			knowledge, death	occurred at the t	me, date and plac	e, and due to the ca	luse(s) and man	ner as stated.
in 24 hours after death. the Funerel Director: After pletely filled in by the fune		29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of my aminer: On the basis of exam and manner stated.	nination and/or inv	restigation, in my	opinion, death occ			due to the cause(s)
within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the tuneral director, page	Medical Certi	(Check only 2 Medical Ex	aminer: On the basis of exam	nination and/or inv	estigation, in my	se number			(Month, Pay, Year)

· ·	For State	State of Maryla	and / Depar <i>Cert</i>	tment of <i>ificate o</i>	Health and f Death		giene Reg. No.	2004	13177
	Registrar 1. Decedent's Name (First, Middle, Las	st)				2. Date of De	ath		3. Time of Death
Physician	_	E.	Mayer			Month	Day	_ 500H	7:50 PM
/Medical Examiner	4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Dea		4c. (County of Death	11.501
Examiner	Franklin Square	Hospital (enter rs. last birthday)	Robe If Under 1 Yes	dale ar If Under 24 Hr	S. 8 Date of Bird	E	Baltin	place (State or Foreign
uneral irector		□ M 3\ 7. Age (#/7)		Months Day			7 (Per) 1924	MD.	ntry)
- F.S.W	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Loca	ation				1	10d. Inside City Limits
Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinst must be notified at once. To Be Completed by Funeral Director	MD. Baltimo		Dunda.						1 ☐ Yes 2 XNo
rec	10e. Street and Number			10f. Zip Code			-	en of What Cou	intry?
a le	1836 Dunmere Road	1			222			SA	
by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	lf.	as Decedent o Yes, specify C □ Yes 2☑ N	of Hispanic Origin? (uban, Mexican, Pue lo <i>Specify:</i>	Specify Yes or No rto Rican, etc.)		4. Race - Ameri Black, White Specify: Wh:	etc.
Completed t	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give k	ent's Usual Occ and of work do O NOT use ret	ne during most of w	orking	16b. Kin	nd of Business/In	ndustry
raumatic event, tra Med To Be Comple	Elementary/Secondary (0-12) 9 years	College (1-4or 5+)	Mana	ager			BAk	ery	
To Be C	17. Father's Name (First, Middle, Last) Robert Hewitt					ame (First, Middle, a Price	Maiden :	Sumame)	
	19a. Informant's Name/Relationship (7			-	eet and Number or F		-		
5	George Mayer III		D. Place of Disposi cemetery, crema	tion (Name of	ce Hill Ro	Date Date		cation - City or T	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ * 4 ☐ Donation 5 ☐ Other (Specify	v) Çar	*	-	tery Apri	1 28,2004	Rosec	tale, MD.	
DC B	21. Signature of Funeral Service Licen	nsee 7	² Cc	Name and Ado	Funeral	Home Of	Dund	alk,P.A	
i d	23a. Part1. Enter the disease, or comp	- V	7	110 Sol	lers Poir	nt Road,	Dund		21222 Approximate
burial-transit uezi al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	a. Due to (or as a cons			spira monar	1840		ois	onset and Death Source One of the Control of the Control One of the Co
음		d							
/ Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 M No 9 Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3 1	Ectopic pregna Other (specify,			2	3d. Date of deliving Month	rery Day Year
<u>م</u>	Part II. Other significent conditions of	contributing to death but not	resulting in the und	derlying cause	given in Part I.	23e. Did t	3	se contribute to	the cause of death? bably 4 □Unknown
Completed						24a. Was		24b. Were aut	opsy findings available ompletion of cause of
E O						perfo	nmed?	death? 1 ☐ Yes	2 No
Be Com	25. Was case referred to medical examiner?					eath (Check only o			
To E	examiner? 1 ☐ Yes 2 X No		2 ☐ ER/Outpatient	30 000		Home 5 ☐ Resi			(4)
<u>ا</u> ا		28a Date of Injury	28b. Time of	28c. le	njury at Vork?	28d. Describe	how injury	occurred	
(42	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		r) Injury		☐ Yes 2 ☐ No				
6 42	27. Manner of Death 1 Natural 5 ☐ Pending	n 29a Place of leiuny A	At home, farm, stre	M 1		28f. Location (City or To	Street end wn, State)	d Number or Rui	ral Route Number,
D 402	27. Manner of Death 1	e 28e. Place of Injury - A	At home, farm, stre	M 1 et, factory, offi	ce e time, date and pla	City or To	wn, State) cause(s)	and manner as	stated.
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not b determined 29a. Certifier Check only 2 Medicel Exar	28e. Place of Injury - A building, etc. (Sp. nysician: To the best of my miner: On the basis of exam	At home, farm, stre ecify) knowledge, death	M 1 et, factory, offi occurred at the estigation, in m	ce e time, date and pla	City or To	wn, State) cause(s) date and	and manner as	stated. to the cause(s)
@ (C)	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Place of Injury - A building, etc. (Sp. nysician: To the best of my miner: On the basis of examand manner stated.	At home, farm, stre ecify) knowledge, death nination and/or inve	M 1 et, factory, offi occurred at the sstigation, in m 29c. Lice	e time, date and plany opinion, death occurrence number	City or To	cause(s) date and	and manner as place, and due a signed (Month	stated. to the cause(s) Dey, Year)
he Funeral Director: Atter t pletely filled in by the funera edical Certification:	27. Manner of Death 1	28e. Place of Injury - A building, etc. (Sp. nysician: To the best of my miner: On the basis of examand manner stated.	At home, farm, stre ecify) knowledge, death nination and/or inve	M 1 et, factory, offi occurred at the sstigation, in m 29c. Lice	e time, date and plany opinion, death occurrence number	City or To	cause(s) date and	and manner as place, and due a signed (Month	stated. to the cause(s)

	_	For State Registrar	State of Maryl	and / L	Certificate of	Death	R	eg. No.	- 1011
hysicia /Medica		Decedent's Name (First, Middle, L	Florenc	e M	yrick	21	2. Date of Dear Month	- 100	3. Time of Death 6:15 Am.
xamine		4a. Facility Name (If not institution, grant 140	ive street and number) 3 Bloomingdale Ave).	4b. City, Town,	or Location of Dea	_{ath} Itimore	4c. County of	Death N/A
neral ector		220-74-9817	Sex 7. Age (In)		thday) If Under 1 Year Months Days			1920	9. Birthplece (State or Foreig Country) A.
lied at	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland	N/A 10c	City, Tow	n or Location	altimore			10d. Inside City Limits
t be not	i Director	10e. Street and Number 1403 Bloomingdale Av	э.		10f. Zip Code	21216	1	0g. Citizen of Wh	nat Country? U.S.A.
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	n U.S.	13. Was Decedent of If Yes, specify Cult		(Specify Yes or No- erto Rican, etc.)		- American Indian, White, etc. Black
ent, the Madical	Completed	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire HOI	pation during most of w ed) nemaker	orking	16b. Kind of Busi	ness/Industry Home
* C	To Be C	17. Father's Name (First, Middle, Las	er Myrick			18. Mother's N	ame (First, Middle, M Elizab	Maiden Sumame) beth Rogers	•
Ta .		19a. Informant's Name/Relationship Vanessa Bryant	(Type, Print)	19b	. Mailing Address (Stree	t and Number or I gdale Ave.	Rural Route Number, Baltimore , Mar	City or Town, St	ate, Zip Code) 6
ury or other tra	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 1 ☑ Donation 5 ☐ Other (Spec	☐Removal from State	cemeter	Disposition (Name of ry, crematory or other pla Cedar Hill Ceme		Date :		ity or Town, State Ore, Maryland
any injury or once.		21. Signature of Funeral Service Lice	cill.		22. Name and Addr Estep I 1300 F	ess of Facility Brothers Fundament	eral Home P.A Baltimore, MD	A. 0.21217	
	ai Examiner	Sequentially list conditions, if any, leading to immediate course. Final Indextyn Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con			14 /)	seep		107
for use a	ician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 25 No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death	3 □Ectopic pregnanc 5 □ Other (specify) _	y		23d. Date of Month	
be d	6	9 □ Unknown \	9⊡ Unknown contributing to death but not	resulting in	n the underlying cause gr	ven in Part I.	23e. Did tob	0/	ute to the cause of death?
page 2	Сотріете						24a. Was ar autopsy perform 1 Yes 2	prio ned? dea	re autopsy findings available or to completion of cause of ath?
direct	erification; to be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death CN Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not 1	28a. Date of Injury (Month, Day Year	2 🗀 ER/Ou 28b. T	ime of 28c. Inju njury Wo	her: 4 🗆 Nursing	Home Seribe hor	nce 6 Other	
completely filled in by the funeral	∟ د	4 Homicide determined	building, etc. (Sp.	ecify)	rm, street, factory, office		City or Town,	, State)	or Rural Route Number,
completely filled in by the funer	edical	29a. Certifier (Check only one) Check only one)	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge iination and	d/or investigation, in my	opinion, death occ	curred at the time, da	te and place, and	due to the cause(s)
E .	2	29b. Signature and title of certifier	122		29c. Licens	se number 2 504 C	29	d. Date signed (A	Month, Day, Year) 2-/34 3-2122
State		30. Name and address of person who 31. Date filed (Month, Day_Year)	completed cause of death (271	Type, Print) HAMMON	DI Fer	1 Rel 15	all on	, 2/22)
ાં egistrai	r	31. Date filed (Month, Day, Year) APR 2 7 200	4 Deales	10	sparks	r			

			1_ State	State	of Maryla	ind / Depa	artment o	f Health a	nd Mental Hy	giene2 (004	13179
			1 - State Registrar AMFIND TTEN 1. Decedent's Name (First, Mid	1 #1830 PER	PHY C830	4/27/Ge	Hicate (of Death	2. Date of De	Reg. No.		3. Time of Death
п	Physici		Ace I	1 (Last)		E. MURPH			Month	Day	Yeer	
	/Medi Examir		4a. Facility Name (If not instituti	on, give street and		J. HOIGH.		m, or Location of	Death	4c. Count	by of Death	5:45 A. ^M
			Crofton Rehab	ilitation	Center		Cro	fton		Ann	e Aru	nde1
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀	7. Age (In yr	s. last birthday)	If Under 1 Y Months Da	ear If Under 2	4 Hrs. 8. Date of Bi Min. (Month, D	rth		lace (State or Foreign
	Director		213-36-1772 Usuel Residence of Decedent	10 111 2/251	65	Yrs.			04/14/		MI)
	show ad at		10a. State 10b. Coun	ty	10c. (City, Town or Lo	cation				11	Od. Inside City Limits
	Man a-f sh ified	tor	MD Ann	e Arundel		Glen '	Burnie					1 ☐ Yes 2 🛣 No
	or 28	Jirec	10e. Street and Number				10f. Zip Cod	de		10g. Citizen of	What Coun	try?
	ath w	rail	8080 Montague				2	1061		U	SA	
	items refr	une	11. Marital Status	Armed	ecedent Ever in Forces?	U.S. 13.	Was Decedent f Yes, specify (of Hispanic Origi Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		ce - America ack, White, e	
336	urs aft	by Funeral Director	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes,	es 2. ⊠No Give er Dates:		1 □ Yes 2 🕱	No Specify:		Speci	fy: W	White
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show is Medical Examinat must be notitied at	ted	15. Decede	ent's Education		16a. Dece	ient's Usual O	ccupation		16b. Kind of E	Business/Ind	lustry
21	ithin 7	Completed	Elementary/Secondary (0-12)	est grade complete College	e (1-4or 5+)	life.	DO NOT use re	one during most of atired)	or working			
	filed with Hygiene. ther than		8				Homemak				Home	
anc	buld be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle						s Name (First, Middle		me)	
Maryland	2 should and Men is marke sumatic	2	Lawrence J. Mt 19a. Informant's Name/Relation			19b. Mailir	ng Address (Str		nna G. Str or Rural Route Numb		State Zin	Code
	a. (a e =		Thomas F. Mur		er		Dakota		nstead, M			0000)
Baltimore,	es 1 and 2 of Health of fitem 27 i		20a. Method of Disposition		20b.	Place of Dispo	sition (Name o	f	Date Date	20c. Location	-	wn, Stete
Ē	Page ment c ant: If		1 ⊠Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other		1	ew Cath			1/24/2004	Balt:	imore.	MD
Salt	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service	e Licensee		22	Name and Ad	dress of Facility	Schwab Fu			ne were
	20E = 3		- Liter 2	S Chalis	-		<u>36 Edmo</u>	<u>ndson Av</u>	re. Baltimo	ore, MD	21228	
			23a. Part1. Enter the disease, shock, or heart failure. List	or complications the st only one cause o	at caused the de in each line.	ath. Do not ent	er the mode of	dying, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 28		Sw.	C					
	Examiner			Due	to (or as a conse	equence of):) = 1:	fid.	1			
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a conse	equence of):	, cc	0 131 1	()			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1 .	101 K	1040	1710	S				
90,	e exectan a	EX	resulting in death) Last	Due	to (or as a conse	equence of):						
68760,	ficate be executed physician and s the burial-transit	dical		d								
_	death certifica attending pl d for use as t	/Me	IF FEMALE:	23c. If ves.	outcome of pregi	nancy						
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Liv	e birth 2 Fe	tal death 3 🗆	Ectopic pregnal Other (specify				ate of deliver onth	y Day Year
0.	that the di ed by the detached	hysi	9 ☐ Unknown	9□ Un			, , , , , , ,	,				
s, P	The law requires that the tee has been signed by the bage 2 should be detache	by P	Part II. Other significent condit	tions contributing to	death but not re	sulting in the ur	nderlying cause	given in Part I.	23e. Did t	obacco use con	tribute to the	cause of death?
Records,	w require been si		1/c Juls	Depr	ess	con			10'	Yes 2□No	3 Probe	bly 4 Donknown
ecc	e law r has be je 2 sh	Completed							24a. Was	an 24b.	Were autop	sy findings available apletion of cause of
E		Cou							perfo	rmed/	death? 1 ☐ Yes 2	
Vital	Physician: Th this certilicate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:					f Death (Check only o	one)		
o		. To	1 ☐ Yes 2 ☐ No 27. Manner of Death		☐ Inpatient 2 [te of Injury	ER/Outpatien 28b. Time of	3 DUA		ing Home 5 Resident	dence 6 Oth)
lon	th. : After s funer	ition	1 Natural 5 Pend		onth, Day Year)	Injury		njuryat Work? I∐Yes 2∐No		low injury occur	100	
Division	Attendi er death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could	mined 256. Pla	ce of Injury - At	home, farm, stre	et, factory, offi	се	28f. Location (Street and Numb	per or Rural	Route Number,
Ö	tal or safte al Dir	Cert	4 El Hornicide	Du	ilding, etc. (Spec	ury)			City or To	vn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai	29a. Certifier 1 Certify (Check only one)	Exeminer: On the	the best of my kr basis of examination	nowledge, death nation and/or inv	occurred at the estigation, in m	e time, date and a ny opinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	anner as sta and due to t	ited. the cause(s)
	ro the within Fo the comple	Me	29b. Signature and title of certifi		/ stated.		29c. Lic	ense number		29d. Date signe	d (Monţh, D	ay, Year)
)			Muly	R VC	en	. N	0	アイナ	3	4/=	2119	70
			30 Name and address of person	who completed ca	ause of death (Ite	em 23a) (Type, I	Print)				- 11	(
			KOBER	T 15.	KYO	OPN	CK	Cro	+ ton	mi	>	
37	Sta Registr		31. Date filed (Month, Day, Year		. Registrar's Sign	nature A	partal	r	/			
			CO HE COLUMN	V 1-1			- H - W					

	1 - For State Registrar	State of M	aryland / De _l <i>C</i> e	partment of Hertificate of t	lealth and M Death	lental Hygien Reg. No		1318
Physician	AUCICA		rtin			2. Date of Death Month Da	y Year	3. Time of Deat
/Medica Examine Funeral Director	4. 5. 100 41	ution, give street and number) -e c+++ o+ B 6. Sex 1 M 2\(\) F	e (In yrs. last birthda 82 Yrs.	Bel A	Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year, June 7, 19	2004 County of Death Lar Ford 9. Birth County 21 Virg	place (Stete or Foi
natural, or items 23a or 28e-f ehow diest Examiner court be notified at	10a. State 10b. Con		10c. City, Town or Abingdo					10d. Inside City Li 1 ☐ Yes 2 ☐
a or 28e-f ellips of the notified	10e. Street and Number 221 Laurenti	m Parkuasi		10f. Zip Code		10g. Ci	tizen of What Cou	intry?
ital Hygiene. d other than "natural", or items 23a or 28e-f ehow event, the Modical Exculter count be notified at Be Completed by Euroral Director	11. Marital Status 1 Never Married 2	12. Was Decedent Armed Forces?		21009 Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☒ No		cify Yes or No- Rican, etc.)	USA 14. Race - Ameri Black, White, Specify:	
100	15. Dece (Specify only hi Elementary/Secondary (0-1	dent's Education ghest grade completed) 2) College (1-4or 5	(Giv life.	edent's Usual Occupa re kind of work done d DO NOT use retired,	uring most of workii	ng	ind of Business/Ir	dustry
and Mental Hygiene. Is marked other than aumatic event, the M	17. Father's Name (First, Mid	dle, Last) nce Rimel, Sr		mbly Line	18. Mother's Name	(First, Middle, Maiden	Sumame)	acturer
if Health and Meritem 27 le marke other traumatic	19a. Informant's Name/Relat Dale W. Marti		221	Laurentum	nd Number or Rura. Parkway	Route Number, City of Abingdon	or Town, State, Zip	
ant: If	4 □Donation 5 □ Othe		Harford	position (Name of sematory or other place) Memorial	Grdns. 4-	20c. Lo	ocation - City or To	own, State
Departr Imports eny inji	21. Signature / Furnar Sag	arts		McComas Fu 1317 Cokes	s of Facility Ineral Hon Bury Road	me, P.A. 1. Abingdor		
ysician Medical	23a. Patri Enter the disease shqck, or heart failure. Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as		Lence	, such as cardiac or	respiratory arrest,	thy	Approximate Interval Between Onset and Deat
physician and the burial-transit authority and the burial-transit authority and are are a second and a second	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence of):				v	
by the attending phitached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
be det	Part II. Other significant cond	ditions contributing to death bu	ut not resulting in the	underlying cause giver	n in Part I.	23e. Did tobacco u	£	ne cause of death
icate has	[]					24a. Was an autopsy performed?	prior to cor death?	psy findings availant of cause 2 2 000
Te la	examiner? 1 □ Yes 2 🛣 No	Hospital: 1 ☐ Inpatier 28a. Date of Injur	y 28b. Time o	of 28c injury	Water ing mom	(Check only one) e 5 ☐ Residence 6 Bd. Describe how injury		()
ral Directal Directal Certif		building, etc				Bf. Location (Street and City or Town, State))	
n 24 h he Fur pletely edic:		lying Physician: To the best of call Examiner: On the basis of and manner state	examination and/or in	vestigation, in my opi	nion, death occurred	nd due to the cause(s) d at the time, date and	and manner as str place, and due to	ated. the cause(s)
To T	29b. Signature and title of cert	fler	nD	29c. License	number	April	signed (Month, L	Day, Year)
	, L	C.		_ 200	5600/	udy	1 20	2004

America Martin

			1 - For State Registrar AMFND TTEM #18	State of Mag PER FH G830	ryland / Depa 4/27/04 Qt	artment rtificate	of H	ealth a Death	and M		giene Reg. No		4	131	82
	Physic /Medi		Decedent's Name (First, Middle, Last CELIA)		MAIEF	₹			2. Date of De Month APRIL	ath Day	2002		Time of Dea	ith M
	Exami		4a. Facility Name (If not institution, give LEVINDALE NURSING 5. Social Security Number 6. Se	HOME	Manual trade in A	4b. City, To	MOR	E				County of D	/ A		
	Funeral Director			M 2 X F	(In yrs. last birthday) 85 Yrs.	If Under 1 Months I	Days	If Under 2 Hours	Min.	8. Date of Bin 04/14/	191 9	9.1	Country E	(State or Fo NGLANI	reign)
	e Marylan 3a-f ehow Illied al	ctor	MD BALTIMOR		10c. City, Town or La BA	cation ALTIMO	RE							rside City Li	
	ath with th	Funeral Director	3106 MARNAT ROAD			10f. Zip C 212						izen of What ILAND	Country?		
980	ges 1 and 2 should be filed within we hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exarting must be notified at	ed by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give Year or Dates:		f Yes, specify	y Cuban ☐ No 【	Specify:	jin? (Spe , Puerto	ecify Yes or No Rican, etc.)			hite, etc.		
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Maryland	should be fi and Mental H s marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) BERNARD BROWN 19a. Informant's Name/Relationship (Ty	na Print)	10h Maille	n Address /C		RAC	HEL	(First, Middle, 	WI	RACHEL			
	s 1 and 2 sho f Health and flem 27 is my other traumy		KURT MAIER / BRC	THER IN LA	W 3106 20b. Place of Dispo	MARNA sition (Name	AT R	OAD	PIKE	I Route Numbe ESVILLE Pate	, MD		3		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		1		CHEVRA AHA	VAS CH	IESE	D 04	1/25, 'SOI	/2004 LEVINS	RAN	DALLS7	OWN.	MD	
	88 2 5 8		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	e death. Do not ente	900 RF	ELST	FRSTO	NW F	RD. PIK	ESVI		1D 212		
8760,	The law requires that the death certificate be executed was required that been signed by the attending physician and usage 2 should be detached for use as the buriat-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	Due to (or as a c	consequence of):	reumir	nui						O.C.	et and Death	
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → 40 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tin 9 □ Unknown	Fetel death 3	Ectopic pregr Other (speci					2	3d. Date of d Month	elivery Day	Year	
ords, P	n requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but in	not resulting in the un	derlying caus	se given	in Part I.		23e. Did to		se contribute		se of death?	
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of	Attending Physician: r death. setor: After this certific. by the funeral director.	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatient 28b. Time of Injury		Other: Injury a Work?	4 Jurs	sing Hom	(Check only or ne 5 Reside 8d. Describe he	ence 6		eecify)		
É	tal or Atters after de rs after de al Directo ed in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)	et, factory, of	ffice		2	8f. Location (Si City or Town	reet and n, State)	l Number or l	Rural Rout	e Number,	
	the Hospital or Ai within 24 hours after of To the Funeral Direc completely filted in by	Medicai	one) Medical Examin	ician: To the best of n er: On the basis of ex and manner stated	amination and/or invi	estigation, in	my opin	nion, death	place, ai	nd due to the cand at the time, d	ause(s) a ate and	and manner a place, and du	as stated.	ause(s)	
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the Maryland , or Items 23a or 28a-f show the Mudical Examiner must be notified at Baltimore, Maryland 21215-0036 'natural' I Hygiene. other than " Pages 1 and 2 should be filed inent of Health and Mental Hygister: If Item 27 Is marked other other traumatic event, permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau **Physician** /Medical **Examiner** The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760. P.O. 1 Division of Vital Records, page 2 Hospital or Attending Physician: funeral director 1 24 hours after death.
 1 Euneral Director: Af letely filled in by the full Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) of person who con pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signa State

Registrar

APR 2 7 2004

State of Maryland / Department of Health and Mental Hygiene 00 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** rowell '*40Р* м 2004 -/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HimoReVA Medica L CONTER DALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days Hours 212427735 1XM 2□ F Director 0 30 1945 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examinations to notified at MD PRINCE GEORGES 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with MEADE RD 20724 2567 U.S.A Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 SYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filled within 72 hours after and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STEEL MACHINIST 12th grade 2yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) C. POWELL WILLIE GERALDINE, F. PERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20724 mit. Pagas 1 and 2 st partment of Health an portent: If item 27 Is r / injury or other treur MICHAEL G. PONELL 3567 FT. MEADE ROAD APT. GII LAUREL, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 04/30/04 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or DWINGS MILLS, MD GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICES 21
5151 BALTIMORE NATIONAL PIKE BALTIMORE MD O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death COLON CANCER Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No ۵ 1 Tes 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of ca 29c. License number 29d. Date signed (Month, Day, Year) MD R15113 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE STREET BALTINUZE MI) GRISHMA Doshi 10 N MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 7 2004 Registra

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 12, Day 2004 Year **Physician** 6:40 PM M Gerald Pritchard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year)
July 28, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 72 172-28-2327 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or items 23s or 28e-1 show other traumatic event, the Wedical Examinar must be notified at 1 ☐ Yes 2 ☐ No Harford Edgewood Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2003 Rockwell Street 21040 USA UTIK | 12. Was Decedent Ever in U.S. Armed Forces? | 1 □Yes 2 □ No | If Yes, Give | Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 Is
any injury or other trau Upper Chesapeake Medical Ctr 500 Upper Chesapeake Drive Bel Air, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 🖔Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. In turn of Funeral Service Licensee Ronald S. Wade rector Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner ischen Sequentially list conditions, it any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ritchard, Gerald 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was gase referred to medical examiner? 1 Tes 2 No 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours a
To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 200 Registrar

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17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suma Stampeck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town Carl Rogers/Son 6515 Cleveland Avenue Dundalk, ME 20a. Method of Disposition 20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 4-23-04 Baltimere, 22 Name and Address of Facility of MD, Inc. 299 Frederick Road Baltimore, 20a. Place of Disposition (Name of cemetery, crematory or other place) 21. Signature of Functional Screen 22. Name and Address of Facility of MD, Inc. 299 Frederick Road Baltimore, 200. Disposition 200. Disposition (Name of cemetery, crematory or other place) 22. Name and Address of Facility of MD, Inc. 299 Frederick Road Baltimore, 200. Disposition 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition (Name of cemetery, crematory or other place) 200. Disposition	10d. Inside City Limits 1 Yes 2 □ No
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	ontribute to the cause of death? 3 Probably 4 Unknown
# & go of thermatic Mitral and acrtic value disease 12 Yes 2 No	b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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1) W 15 2 MD 104383 April	121, 2004 Ray vas Orela
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		•	State of Maryland / Dep State Registrer State of Maryland / Dep	artment of Health and Me <i>rtificate of Death</i>	ental Hygier	
			Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	3. Time of Death
	Physicia		Warren K. Rogers			21 2004 7:15 P.M.
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	•	4c. County of Death
	xam.	Ÿ.	334 Foreland Garth	Abingdon		Harford
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		218-28-6191 1⊠M 2□F 69 Yrs.		6/04/193	
	D D		Usual Residence of Decedent			
	how	_	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 ☐ Yes 2 🗖 No
	e Ma	cto	MD Harford Abing	don		
	or 28	Director	10e. Street and Number	10f. Zip Code.	10g.	Citizen of What Country?
	23a		334 Foreland Garth	21009		USA
	ems ems	Funeral		Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
9	or II	YF	1 Never Married 2 Married 1 Never Married 1 Serves 2 No 1952-	1 ☐ Yes 2 🕱 No Specify:		Specify:
ğ	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1956		400	White
Ÿ	nat nat	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation of kind of work done during most of working DO NOT use retired)	7	b. Kind of Business/Industry
2	withir	m du	Elementary/Secondary (0-12) College (1-4or 5+)			Retail
7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow int, Ita Medical Eraminer must be multified at		17. Father's Name (First, Middle, Last)	lesman 18. Mother's Name (First, Middle, Maid	
Ĕ	a la b	Be		, w _i , s		
Ž	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Itam 27 is marked other than "natural; or Itams 23a or 28a-1 show it Itam 27 is marked other than "natural; or Itams 27 is marked outer than "a Medical Examinat must be notified at	٩	Warren Joseph Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Marie A. ing Address (Street and Number or Rural)		ity or Town State Zin Code)
S	12 si h an 7 ls r treur			Foreland Garth Abi		
<u>က်</u>	ges 1 and 2 t of Health If Itam 27 I		20a Mathad of Disposition 20b, Place of Disp	osition (Name of Da	1,000	Location - City or Town, State
ŏ	Pages nent of I int: If Its iry or o		1 ⊠Burial 2 □ Cremation 3 □ Removal from State cemetery, cre	matory or other place)		
altimore, Maryland 21215-0036	t. Part rtant rtant			w Mem. Park 04/24/		ykesville, MD
Ba	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility terling Ashton Schw	ab Funer	al Home, Inc.
	40140		23a. Part1. Enter the disease, or complications that caused the death. Do not en	36 Edmondson Ave.		
6			shock, or heart failure. List only one cause on each line.	/ 1	respiratory arrest,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Mctastatic Lung	Cancer (NSELC)		2yr
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	ed isit	Examiner	il ariy, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	ical E	,,			
87	phys the	dic	d			
9 ×	ding se as	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of delivery
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0	w requir been si should I	ete	McTastatic Renal Cancer (Papillary True II Diabetes		04- 116	Odb Mars subserve findings available
Sec.	e faw has l	Completed	1710 11 01260165		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
<u></u>	cate				1 ☐ Yes 2 🕱	
Division of Vital Records,	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	26. Place of Death /	/	
ot	Phys this al dir	<u>1</u>	1 Tes 2 No 1 Inpatient 2 EN/Outpatie	FIL 3 DOA 4 INUISING HOME	e 5 Z Hesidence	e 6 Other (Specify)
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<u>S</u>	Attending in death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		of Location (Street	t and Number or Rural Route Number,
<u>></u>	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	rieer, ractory, onice	City or Town, St	
است	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, data and place, an	nd due to the cause	e/s) and manner as stated
	Hos 24 hc Fun stely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or i one) and manner stated.			
	To the Hospital within 24 hours and to the Funerel completely filled	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	⊬ ≱ ⊬ ŏ ∣		Valve no	D 0054717		4/23/04
	6		30. Name and address of person who completed cause of death (Item 23a) (Type			(1-7/-)
	*		RAMEEN MOLANI, MO. 1075	S FALLS RO SVITE 470	LUTHER	VILLE, MD 21093
	Sta	ite.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1. 1		
- A.C.	Regist		APR 2 7 2004 Seneral &	Bosels!		

Rogers, Warrer

Gregory Salisbury Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02718 State of Maryland / Department of Health and Mental Hygien 🏻 🧎 For State Registrar RJCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gregory E. Salisbury April_ 2004 20 /Medical 0755 A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Anne Arundel County Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 1, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**25** M 2□ F 1955 West Virginia 214 66 0460 48 Yrs. Director Usual Residence of Deceden the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ŏ 21060 U.S. Items 23a 610 Opel Road death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Itam 27 is markad other than "natural", or Iten 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Triangle Printing 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wallace Salisbury Effie Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billie Salisbury / Wife 610 Opel Road Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If ita 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Bayview Crematory 4/22/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** COLONOR afero throm 6 disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter of Janying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last certificate be execu Due to (or as a consequence of) Physician/Medical IF FEMALE Division of Vital Records, P.O. Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed? Yes 2□No 25. Was case referred to medical examiner?
1 △ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 □ DOA 2 1 Inpatient this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide Hospital 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) within 2 and manner stated. To the

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

Name and address of person

31. Date filed (Month, Day, Year)

om 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Stanature

7 2004

vho completed cause of q

Coast 5

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 21, 2004

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		For State of Ma	aryland /	Depa Cer	rtment of F	lealth and M Death		giene 201)4	13190
	10	Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth	Yeer	3. Time of Death
Physici /Medi		Robert Sco	ott She	1ton			APRIL	22 20	204	01:45AM
Examir	ner	4a. Facility Name (If not institution, give street and number)	10001	_	4b. City, Town, or BALTI	r Location of Death		4c. County o	of Death	
Gurrani		SAINT AGNES HEALTH	e (In yrs. last I		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		ce (State or Foreign
Funeral Director		214 50 3353 1 [™] № 2□ F	54	Yrs.	Months Days	Hours Min.	(Month, Day Feb. 11	, Year)	West	⁰ Virginia
p .		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	um or l or	ation				100	I. Inside City Limits
faryla	5	Maryland N/A	,	timo					100	1. Inside City Limits 1. X Yes 2 □ No
the N	Director	10e. Street and Number	Dar	CIMO	10f. Zip Code			10g. Citizen of W	hat Countr	v?
3a or		2152 Herman Avenue			212	30		U.S.		rij i
deatl	ner	11. Marital Status 12. Was Decedent I Armed Forces?	Ever in U.S.	13. W	as Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race	- American	
36 s after	y Fu	1 Never Married 2 Married 1 Yes 2 K	No		☐ Yes 2 No	Specify:	, ,		Whit	
Phour stural	ed b	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	16	a. Deced	ent's Usual Occup	ation		16b. Kind of Bus	siness/Indu	stry
21215-0036 Id within 72 hours aft giene. The "natural", or the Mudical Ergan,	Completed by Funeral	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	i+)			during most of worki	ng	~ .		•
21, the	Con	8th		Lab	orer			Constr		on
Maryland d 2 should be file th and Mental Hy I? Is marked oth	Be	17. Father's Name (First, Middle, Last) Robert Shelton				18. Mother's Name	ty Jo Jo		9)	
Iryld should nd Me mark matic	2	19a. Informant's Name/Relationship (Type, Print)	1:	9b. Mailing	Address (Street	and Number or Rura			State, Zip C	ode)
Maith ar alth ar 12716		Betty Jo Shelton / Mother	: 2	2152	Herman A	venue	Baltimo	re, Mary	1and	21230
Baltimore, semit. Pages 1 a Separtment of Hes mportent: If item mp injury or othe ance.		20a. Method of Disposition 1 □ Burial 2 XCremation 3 □ Removal from State	20b. Place ceme	of Dispos tery, crem	ition (Name of atory or other place		ate	20c. Location - (City or Town	n, State
Lim Pag Iment tent: I		* 4 □ Donation 5 □ Other (Specify)	Bayv		rematory			Baltimon		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23s or 28e-f show any injury or other treumatic event, the Medical Evantment required must be invitibled at once.		21. Signature of Funeral Service Licensee	tt	40	001 Ritch	ss of Facility Go nie Highwa	y Bal	timore,		, P.A. land 21225
100		23a. Part1. Enter the disease, or complications that Jaised shock, or heart failure. List only one cause of each in	the death. D	o not ente	r the mode of dyin	ng, such as cardiac o	r respiratory ari	rest,	lr lr	pproximate hterval Between Onset and Death
Physician /Medical					DINTES	TINAL	BLEE	ED		SAYS !!
Examiner		Due to (or as	a consequenc	e of):						
	ner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	a consequenc	e of):	-					
be executed burial-transit	Examiner	that initiated events								
8760, sate be ex	al E	Due to (or as	a consequenc	e or).						
687 687 ifficate g phys	edical	d								
Records, P.O. Box 68760. The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth	of pregnancy	th 3□	Ectopic pregnancy	,			of delivery	
P.O. B. that the death ed by the atterded for	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown			Other (specify)			Mon	th Di	ay Year
P.C. that the	, Ph	Part II. Other significant conditions contributing to death be	ut not resulting	in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contril	bute to the	cause of death?
cords, vrequires to been signed should be controlled.	d by						1 🗆 Y	es 2□No 3	3 🗌 Probab	ily 4 X Unknown
OBER I Record The law requir	Completed						24a. Was a		ere autops	y findings available
.OB	mo						autops perfor	med? de	ior to comp eath?] Yes 2[letion of cause of
RO f Vital F ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death				
of V	ည	1 ☐ Yes 2 🔀 No Höspitäl: 1 🗹 Inpatie		Outpatient		4 Nursing Hor		ence 6 Othe		
Sion o's tending Pheath.	tion	27. Manner of Death 1 SNatural 5 Pending (Month, Day) 2 Accident investigation	Year)	. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	zed. Describe n	ow injury occurre	u	
	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Inju	ury - At home,	farm, stre			28f. Location (S	treet and Number	r or Rural F	Route Number,
	Certification:	4 Homicide determined building, etc	с. (Ѕреспу)			Į.	City or Tow	n, State)		
전 전 중수물을	Medical	29a. Certifier (Check only one) Check only one)	examination :	lge, death and/or inv	occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurr	and due to the c ed at the time, d	ause(s) and man late and place, ar	ner as state nd due to th	ed. ne cause(s)
within 2 to the complet	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed	(Month, Da	y, Year)
		Jasm and	- \		A5 2	243852	8	APRIL	22,	2004.
1		30. Name and address of person who completed cause of d				BALTI	mogs	000	1.22	a
Ste	ate	RABINA MALIK, MD. 31. Date filed (Month, Day, Year) 32. Registra	ar's Sonature		NO HVE	, 1381611	MURC	110 2	-126	
Regist		APR 2 7 2004	plar.	0 1	Spark					

Obvoicie	,	 Decedent's Name (First, Middle, L 	ast)						2. Date of De	eath 4/2	23/04	ear, 3	. Time of Death
Physicia: /Medica	_	Marie Haag Sch				1			04	Do	2- 0	7 6	8105 91
Examine	er	4a. Facility Name (If not institution, g	11	ber)	C	n		Location of De	ath	-	County of		
Funeral		Franklin Square 5. Social Security Number 6.	Sex 7	(E/)+C . Age (In yrs.	last birthday)	If Under 1 Y	/ear	la le If Under 24 H		rth	altir	. Birthplace	(State or Foreig
Director		218-03-8130	1 X M 2 □ F	86	Yrs.	Months D	ays	Hours Mi	n. (Month, Da Nov. 7,	ay, Year) 191		Country) Maryl	
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or L	ocation						10d.	Inside City Limit
rs after death with the Marylar, or Items 23e or 28a-f show raning must be notified at	ō	MD	N/A		1	Baltimo	re						1X∏Yes 2 □ N
or 28a	Funeral Director	10e. Street and Number	21/ 22			10f. Zip Co				10g. Citi	izen of Whe	t Country?)
23e c	E C	5932 Marluth A	venue					206			ed St		
after dea or items	unel	11. Marital Status	12. Was Deced	ces?	J.S. 13.	Was Decedent If Yes, specify	t of Hi Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	0-	14. Race Black, \	American I White, etc.	ndian,
within 72 hours after death with the Maryland with in 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Medical Exeminer must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat	, **		1 ☐ Yes 2 X	No.	Specify:			Specify:	W	Thite
d 2 should be filed within 72 hours att th and Mental Hygiene. 77 is marked other than "natural", or treumatic event, if a Medical Exerti	ted	15. Decedent's	Education		16a. Dece	ident's Usual O)ccupa	ition	un dein n	16b. Ki	ind of Busin	ess/Indust	ry
thin 7	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use n	retired,	uring most or v	ronking				
filed wi Hygien Sther th	ပ္ပ	12	4		Ног	nemaker		40.11-4-1.1				Home	
ntal H d otl	Be	17. Father's Name (First, Middle, La	51)						ame (First, Middle		Sumame)		
should Ind Men	ို	Andrew Haag 19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ina Address (Si	treet a		ary Imhof Rumal Route Numb		or Town. Sta	te. Zip Coo	de)
permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other treumatic event, tra Medical pages.			ster		17	_			rbutus, M			,,	
f Healifem other		20a. Method of Disposition	_		Place of Disp	osition (Name o	of	T	Date		cation - Cit	y or Town,	State
Page Page Internation	1	1 ☐XBurial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of the Contro		tate Me	eadowro	dige orial P		/ 2/	5-2004	E1k	ride	, MD	
permit. Pages 1 a Department of He Important: If item any injury or othe once.		21. Sign ture of Funeral Service Lic	20500	- 12.	2	2. Name and A	Addres		orose Fun				
1 89 6 8 9	A	Calllago	HULK	16013	分 13	328 Sul	phu	ır Sprin	ng Rd., A	rbut	us, M	D 212	.27
· 		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ca ly one cause on ea	used the dea ch line.	th. Do not en	ter the mode of	f dying	g, such as card	iac or respiratory a	irrest,		Inte	proximate erval Between set and Death
Physician	Ì	Immediate Cause (Final disease or condition resulting in death)	_a. 1500	in t	letas	stavi	5					OII	Sot and Death
/Medical Examiner		Todalisi g 11 douilly	Due to (o	ras a consec		arci	50	ma					
	ē	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (a	ras a conse		21011	1101	TILL					
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eath certific attending p	lan	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	al death 3	⊒Ectopic pregr				1	23d. Date of Month	f delivery Day	y Year
ires that the de signed by the a l be detached f	yslc	1 Yes 2 No	4⊟ Pregna 9⊟ Unknov	nt at time of o	death 5	Other (specif	ту)						
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or Attending Physicien: The law requires that the death certificate be eatler death. Director: After this certificate has been signed by the attending physiciar in by the funeral director, page 2 should be detached for use as the burit	Completed								24a. Was		24b. Wer	e autopsy	findings availab
The lav	E								- auto perfo 1 ☐ Yes	psy ormed? 2 X No	deal	r to comple th? Yes 2□	ition of cause o No
iclen: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place of D	eath (Check only		1 - 1	744	
hysic his ce	2	1 ☐ Yes 2 No			ER/Outpatie		Othe	4 Nursing	Home 5 ☐ Resi	idence (6 □Other (Specify)	
ding Physicien: The lawn. After this certificate has funeral director, page 2	<u>-</u>	27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of (Month	Injury , Day Yeer)	28b. Time of Injury		Mork	.?	28d. Describe	how injur	y occurred		
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after Direction by	Certification:	4 ☐ Homicide determine	building	g, etc. (Speci	fy)	reet, factory, or	IIICe		City or To	wn, State)	n nurai no	ute reumber,
	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the base aminer: On the base and manner	sis of examina	owledge, deal ation and/or ir	th occurred at the avestigation, in	the tim	e, date and pla inion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manne place, and	er as stated due to the	t. cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	7			29c. Li	icense	number		29d. Dat	te signed (N	fonth, Day,	Year)
- > - 0		> New	June			D	281	717		41	1221	14	
								111	uare D	_/_/	0010		

State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month Yeer **Physician** April 24, 10:15p Cornelia D. Sadler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1815 Butterfly Court Howard Svkesville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) WV 8. Date of Birth (Month, Day, Year) July 26, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 85 Director 178-07-6607 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28e-f show other traumatic event, the Medical Examinar must be notified at MD Sykesville 1 ☐ Yes X☐ No Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 1815 Butterfly Court USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any njury or other traumatic event, the Medical Education 2000. items 23a by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give ↑ Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🂢 No Specify Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Insurance Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alfred T. Dillard Mayme LaRue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Nancy Lindsey (Sister) 1004 Dale Place Carlysle, PA 17013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Crestlawn Mem. Gardens 4/28/04 Marriottsville, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee AATGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition years **Physician** Terroscha resulting in death) /Medical Due to (or as a consequence of) Examiner 8/00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as Examiner The law requires that the death certificate be executed burial-transit evebrova80 ala that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physicien Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) should be detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably rounded 1 🗌 Yes 2 No 4 □Unknown been 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has 1 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 3 DOA this within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Fo the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 36246 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Beaver brook Rd Columbia MD 21049 shert H MD 31. Date filed (Month, Day, Year) APR 2 7 2004 32 Registrar's Signature State Registrar

			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	+ 13193
	Physici /Medic		1. Decedent's Name (First, Middle, Las		ESSLER			2. Date of De Month APRIC	Day Yee	. 11 \ 20 D H
	Examin		4a. Fecility Name (If not institution, give GOOD SAMARITAN HO 5. Social Security Number 6. Security Number	street and number)	(In yrs. last birthday)	4b. City, Town, o BALTII If Under 1 Year	If Under 24 Hrs	h 8. Date of Bird	4c. County of De N/A	eath Birthplece (State or Foreign Country)
	Director		219-18-6719 ¹ Usual Residence of Decedent	DXM 2□F	78 Yrs.	Months Days	Hours Min.	5/25/93		ARYLAND
	Marylan a-f ehow	tor	10a. State 10b. County N/A	1	10c. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 No
	th with the 23m or 28s	ai Director	10e. Street and Number 5908 BURGESS AVE			10f. Zip Code 21214			10g. Citizen of What USA	Country?
96	72 hours after death with the Maryland Insturet, or tleme 23a or 28a-f ehow dical Exeminer must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1X☐ Yes 2 ☐ N 11 Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Ar Black, W Specify:	
21215-0036	⊆ 2	Completed t	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12)	ucation	(Give	dent's Usual Occup kind of work done DO NOT use retire ESMAN	during most of wo	rking	16b. Kind of Busines	
land 2	be filed stal Hyg od other event,	To Be Co	6TH GRADE 17. Father's Name (First, Middle, Last) WILLIAM SCHUESSLE	CR	DAD			me (First, Middle, E SHELD)	, Maiden Surname)	IVG
Ž	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (7 FRANCES M. SCHUES			ng Address (Street BURGESS		BALTIMOF	er, City or Town, State	e, Zip Code) 2 1 4
imore	100		20a. Method of Disposition 1 ☐ Burial 2 【3Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		METRO CR	natory or other pla EMATORY,	INC. $4/2$		20c. Location - City CATONSVILI	LE, MD
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licen	Hup	_ 8	521 LOCH	RAVEN BL	VD. TOWS	SON, MD 2	HOME, P.A. 1286
	Cate be executed by Science be executed by Medical Examiner by Science of Sci	al Examiner	23a. YarY. Enter the disease, or composition of the	b. Due to for as a c.	a consequence of):		ng, such as callular	con respiratory an	11001,	Approximate Interval Between Onset and Death
Box (death certifica e attending ph id for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnanc	у		23d. Date of d Month	felivery Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ont <i>r</i> ibuting to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.		obacco use cont <i>ri</i> bute Yes 2 ☐ No 3 ☐	to the cause of death? Probably 4 Onknown
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	fing Physic After this ce funeral direc	tion; To Be	25. Was case referred to medical exampler? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatier 28a. Date of Injun (Month, Day	28b. Time o	28c. Injui	ner: 4 🗍 Nursing H		one) dence 6 Other (Sp	pecity)
É	ial or Attendi s after death. al Diractor: A ad in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (5 City or Tow	Street and Number or i	Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	edical	29a. Certifier 1 Certifying Ph. (Check only one) 1 Medical Exam	vsician: To the best o iner: On the basis of and manner stat	examination and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier 30. Name and address of person who	Fulla completed cause of da	Apath (Item 23a) (Type	29c. Licens			29d. Date signed (Mo.	nth. Day, Year) 25 2004 MD21239
	Sta Registr		KALATHIC S 31. Date filed (Mooth Day, Year).	HASHIDY		6000	SAMAR	CTAN H	FOR PITAL	MDSUZ

			1 - For Amend Item 16b	State of M per FH,G830	laryland),04,27/(/ Depa 24d eb e	artment rtificate	of He	ealth a Death	ind Me	ntal Hy	giene Reg. No	200	4	13194
ı	Physici	an	1. Decedent's Name (First, Middle, Las							2	. Date of De Month	ath Day	y Y	/ear	3. Time of Death
	/Medic	cal	Paul Gilbert S 4a. Facility Name (If not institution, give				4b City	Fown or I	Location o		April	2	County of	004 Dooth	04:05 AM
	Examir	ier	Sinai Huspita	1 0 - 1	timor	e	Ra	14:4	ore	Dogin		40.	. County of	Dealii	
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. las		If Under Months	Year Days	If Under 2 Hours	Min. D	Date of Bir	th Y 925	38	Birthp	lace (State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation							1	0d. Inside City Limits
	Maryl f sho	tor	Maryland Baltimo	ore	F	Reist	erstov	vn							1 ☐ Yes 2 ☐ \ No
	h the	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wh	at Coun	itry?
	23e c	ra D	227 Mysticwood F	Rd.			2	21136	5			U.	.S.A.		
36	d within 72 hours after death with the Maryland joine. Ir then "neturel", or Items 23e or 28e-f show the Medical Evantiner rust be notified at	by Funeral I	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? K No	'	Was Deced fYes, spec 1 ☐ Yes 2	ify Cuban	panic Orig , Mexican Specify:	rin? (Specit , Puerto Ric	fy Yes or No can, etc.)	>-	14. Race - Black, Specify:	Americ White,	
9	72 hou		15. Decedent's Ed (Specify only highest gra	lucation		16a. Deced	dent's Usua kind of wor	l Occupat	tion	of working		16b. K	ind of Busi	ness/Ind	dustry
Maryland 21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	vice N	e retired)	_	or working			mobile Autom		.e-
nd	tbe filed ntal Hygin ed other event, t	Be	17. Father's Name (First, Middle, Last)	Caba	7			1		,	First, Middle,				
<u> </u>	2 should be and Mental Is marked o	2	Frederick Xavie 19a. Informant's Name/Relationship (7)			10h Mailin	Address				tella Route Numbe				Cadal
Ma	17 15		Linda Rockenhaus			_					Myers				
Baltimore,	eg = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify		cem	e of Dispo	sition (Nam natory or ot emato:	e of her place)	Date	9	20c. Lo	cation - Ci	ty or To	wn, State
altir	permit. Pa Departmer Importent eny injury once.		21. Signature of Funeral Service Licen		11001			_	-		pel P.		C.I.IIOI V	C 9 1.	
	hysician and physician and secured strength with the purial-transit strength with the purial-transit secured by the purial-tra	Examiner	23a. Part. Enter the disease, or companies shock, or heart failure. List only of the shock of th	aDue to (or as	s a consequer	ebra nce of): us fou nna of):	IL H				espiratory a	rrest,			Approximate Interval Batwaen Onset and Death 5 day 5
P.O. Box 68760,	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal de	eath 3	Ectopic pre						23d. Date o		ry Day Year
	Se de	by	Part II. Other significant conditions of	ontributing to death t	but not resultir	ng in the ur	ndertying ca	use giver	n in Part I.		23e. Did to		- /		e cause of death?
Vital Records,	e law has b	ompleted									24a. Was autop perfo 1 \sum Yes		prig	r to con	psy findings available apletion of cause of
ita	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death (C	Check only o	-			
o	Phys this al dir	္	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ury 28	VOutpatien Bb. Time of Injury		lc. Injury a Work?	at Hull	280	5 ☐ Resid 1. Describe h			(Specity)
Division	ol or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	njury - At home etc. (Specify)	e, farm, stre	eet, factory,	office		28f	Location (5 City or Tox			or Rural	Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the best niner: On the basis of and manner st	of examination	edge, death n and/or inv	occurred a restigation,	t the time	, date and nion, death	place, and occurred	due to the at the time,	cause(s) date and	and manne place, and	er as sta I due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License	number			29d. Dat	e signed (A	Month, E	Day, Year)
)			Scatt Sus	M.P.			6	?ES.	000			Apr	1/ 26	6,2	1004
	10		30. Name and address of person who of Single Hospital (Month, Day Year) APR 2004	completed cause of	death (Item 23	3a) (Type,	Print)		11 <	0	^				
	Sta	to	31. Date filed (Month, Day Year)	tal of B	rar's Signature	ore	nuls) CB	17 26	CD, H	1.0.				
	Registi		APR 2 7 2004	 											

Schoennagel, Paul

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1:06pM 20 2004 evin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laflata Medical C Civista enter If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Fgreign Country) **Funeral** 12 M 2□ F Director none Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-fearment into or other traumatic event, If a Menter E. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Indian Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 1 Tes No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be amb/ 2 19a. Informant's Name/Relat Inship (Type, P 1) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 E. Charles Street Laplata, MD 20646 Civista Medical Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21. Si ature o Funeral Service Licenses 19/ State Affatomy aboard 655 W. Baltimore Street naca Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Pert1 Enter the disease, or complications that caused the death, shock for heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Dualti (or as a consequence of) The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) use as the IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy jo Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 99 2 No 1 Yes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 npatient 2 ER/Outpatient 3 DOA

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician:

Medical Certification: To Be this completely filled in by the funeral After death within 24 hours after deat To the Funeral Director: 2

DHMH 17 Rev 1/2001

Makonhen State Registrar

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Thomicide

29b. Signature and title of certified

30. Name and address of person

Ze 31. Date filed (Month, Day, Year) APR 2

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

who completed cause of death (Item 23a) (Type, Print)

lleke

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Bay View

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State Registrer AMEND ITEM #5,9,15,16a&b,17' Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** April 13,200K 10:15 John Henry Springs /Medical 4b. City, Town, or Location or Deau.

Lyger Mar Low Fri.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan 7, 1950 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner each / eaf Prince George's 12811 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F unk 220-54-1052 54 Yrs. Director MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MD Prince Georges Upper Marlboro 1 ☐ Yes 2 🗓 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ö 12811 Peach Leaf Court 20774 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Ut 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1)(Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify Š black. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) unk g College (1-4or 5+) CUSTODIAN APT BUILDING Pages 1 and 2 should be filed nent of Heelth and Mental Hygisht: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk unk Be RENDERSON SPRINGS ERNESTINE MCCLOUD unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prince George's Police Dept 730 S.PAYNE STREET ALEXANDRIA, VA. 22314 SHARRE SPRINGS / daughter

20a. Method of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F.
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖺 Other (Specify) in State 21. Signature of Euneral Services Censee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arteroschentic Hyperterine Heart Diseas Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Secuentially list moditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical phys IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. | 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Ď 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1□ Yes 2⊟No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ္ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After s after dea. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in To the Hospital within 24 hours a To the Funeral L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier Anloso 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print) Stalutdon Sylverer 3001 Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death **Physician** BERNICE SOWDERS 3:00 AM April
4b. City. Town, or Location of Death 24, 2004 4c. County of Death /Medical 4e Fecility Neme (If not institution, give street end number) Examiner Lorien Nursing & Rehab. Center Columbia, Howard If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) Funeral Months Days Hours 1□ M 2X F Director 89 522-28-0278 1914 Missouri Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-fahov the Modical Examiner must be notified at MD Howard Columbia 1 Yes 2 No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with ò 7080 Cradelrock Way-Apt.312 21045 USA items 23a 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced "neturel" Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Homemaker Own Home permit. Peges 1 and 2 should be file.
Depertment of Health and Mental Hyg important: If Item 27 is merked other eny injury or other treum-" other o 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Starr <u>Ella Mae Johnson</u> 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) R. William Sowders/son 10082 Fair Beauty, Columbia, Md. 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Cem.April 30, Ft. Gibson, Ok. 1 XBurial 2 □ Cremation 3 □ Removal from State Gibson Nat'l 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Rd, Columbia, Md. 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DEMENTIA Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physician end for use es the buriel-trensit or Attending Physicien: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown COMGESTIVE HEART à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy PNEUMONIA 2X No 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Mariner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funerel Director: A completely filled in by the fa investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edlcai 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2MA D0060560 Shote mal 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 201-RIVER NECK 109 CHETERPAL 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

			1 - For State Registrar	ate of Marylan	d / Depa		Health a	and Menta		ne2(13198
		rigi	Decedent's Name (First, Middle, Last)			-		2. Dat	e of Death			3. Time of Death
	Physici		Thomas Clarke T	avlor				AA		Day 20	Year 2004	6:20FM
12.0	/Medic Examir		4a. Facility Name (If not institution, give stree			4b. City, Town	n, or Location		-12		ty of Death	
8. 7	Evdium	į.	SAINT AGNES	HEALTH	CARE	Bal	TIMO.	PE				
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Ye	ar if Under	24 Hrs. 8 Date	e of Birth	nar)	9. Birthp	lace (State or Foreign
	Director		219-44-6762 1X M	^{2□ F} 60	Yrs.	Months Day	ys Hours	Min. (Mo	nth, Day, Y. 27, 1	943	Mary	land
	P. ,		Usual Residence of Decedent									
	show	_	10a. State 10b. County		, Town or Lo						11	0d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	cto	Maryland Howard	E	11icot	t City						
	or 2	Funeral Director	10e. Street and Number			10f. Zip Code			10g		What Coun	try?
	ath w	ra	3225 Green Forest			210				U.S.		
	er de	nne	A A	Vas Decedent Ever in U. Armed Forces?	S. 13. \	Nas Decedent of f Yes, specify C	of Hispanic Ori Juban, Mexicar	igin? (Specify Ye n, Puerto Rican, e	s or No- etc.)		ice - Americ ack, White, (
36	s afti	by F		XYes 2 □ No f Yes, Give ∕ear or Dates:		1□Yes 2█N	No Specify:			Speci	ify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28e-f show he Mcdical Examiner must be notified at	ed t	15. Decedent's Education		16a Decer	tent's Usual Occ	cupation		16	h Kind of F	Business/Inc	
15	in 72 " na Kudio	ojet	(Specify only highest grade cor	npleted)	(Give	dent's Usual Occ kind of work dor DO NOT use ret	ne during mos tired)	t of working	.0	D. 14110 01 1	54311103371110	lastry
12	with lene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		alance				Const	ructi	on
	i filed I Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (First,	Middle, Ma.	iden Suma	me)	
lan	ould be filed Mental Hygis arked other atic event, II	To B	Jesse Taylor				Eliz.	abeth Ba	nkert			
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Its M.	-	19a. Informant's Name/Relationship (Type, I	Print)	19b. Mailir	ng Address (Stre	et and Numbe	er or Rural Route	Number, C	ity or Town	n, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23s or 28e-f show may injury or other traumatic event, the Medical Examiner must be notified at once.		Margaret K. Taylor	(Wife)	3225	Green	Forest	Ct. E11	icott	City	, MD	21042
Baltimore,	es 1 a of Hea of Heam fitem r othe		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other p	olace)	Date	20	c. Location	- City or To	wn, State
E	Pages nent of int: If it		1 ☐ Burial 2 🖾 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	Val Holli State		sh. Crem	1	4-25-20	004 La	ure1,	Mary	land
alti	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee	~ ^			•					
ñ	Depariment Department		PEDGH		W1	tzke Fu 30 Edmo	neral . ndson	Home of Ave. Cat	Caton	svill 11e.	e, In Marvl	c. and 21228
			23a Part1. Enter the disease, or complication shock or heart failure. List only one car	ons that caused the death								Approximate Interval Between
	Physician		Immediate Cause (Final			_						Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a consequ		IC CER	EBROY	IASCULA,	R M	CCIDE	NT	L24 Hours
	Examiner											
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequ	ence of):							
¥	cuted id ansit	Examiner	Cause (Disease or injury that initiated events									
o,	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):							
,092	ate be executed sysician and he burial-transit	cai	d									
68	The law requires that the death certificate in the has been signed by the attending physionage 2 should be detached for use as the	Med	IS SEMALS									
Вох	th cer endir r use	Physician/Med	23b. was decedent pregnant	f yes, outcome of pregnal □ Live birth 2 □ Fetal		Ectopic pregna	псу				ate of delive	*
	deal	sicie	1 Tyes 2 No	Pregnant at time of de		Other (specify)				М	onth	Day Year
P.0	at the by th	hy	9 Unknown	SINTOWN						-		
	w requires that been signed to should be deta	by F	Part II. Other significant conditions contribu	iting to death but not resu	ılting in the u	nderlying cause	given in Part I	. 23				e cause of death?
ord	equir en si ould	ted							1 🗌 Yes	2 ∐ No	3 Proba	ably 4 Minknown
Records,	law nas be	Completed						248	a. Was an autopsy	24b.	Were autop	osy findings available inpletion of cause of
Ä	The ate ha	Eo						1 [performe	No No	death?	2 No
Vital	ysician: The law is certificate has b director, page 2 s	Bec	25. Was case referred to medical				26. Place	of Death (Check				
>	≥ .ºº 0	2	examiner? 1 Yes 2 No Hospi	ital: 1 Impatient 2 🗆	ER/Outpatien	t 3 DOA	Other: 4 🗆 Nu	rsing Home 5	Residenc	e 6 □Ot	her (Specify)
J of	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 Pending	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In	njury at Vork?	28d. De	scribe how	injury occu	rred	
Ö	Attending or death. ector: After by the fune	atic	2 Accident investigation				□Yes 2□	No				
Division	er de	tific	3 ☐ Suicide 6 ☐ Could not be determined	Be. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, offic	СӨ		ation (Street or Town, S		ber or Rural	Route Number,
	ital o	Certification;										
	lospi I hou unei unei	cai	29a. Certifier 1 Certifying Physicie 2 Medicel Exeminer:	n: To the best of my know	wledge, death	occurred at the	time, date an	d place, and due	to the caus	e(s) and m	anner as sta	ated.
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one)	and manner stated.								
	With To	2	29b. Signature and title of certifier				ense number	17		_	ed (Month, L	
	(.		10-47			P	156	44	/	4ARI	2 26	2,2004
	V		30. Name and address of person who comple	^				MA		-7	170	a
	`		900 CATON	AVENUE		BALTIN Local	nord	MD			122	7
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 7 2004	22. Registrar's Signar	y .	low V.	/					
	negisi	aı	7111 ~ 1 2004	7	-	yours!						

			1 - For State Registrar	State of Maryland		nent of He			giene Reg. No	WG - C	13199
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Jeanne		Van	Domb	pera	2. Date of De Month April	Day 23,	y Year 2004	3. Time of Death 6:33 P M
	Examir Funeral Director		4a Eacility Name (If not institution, pive in the state of the state o	Cins Hospfi	ast birthday) If	City, Town, or	Location of Death OF CONTROL If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De AUG 8	*h	9. Bin Co	th hplace (State or Foreign unitry) Jersey
	ith the Maryland or 28e-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		r, Town or Location	n					10d. Inside City Limits 1 ☐Yes 2 ☐ No
	with the	I Direc	10e. Street and Number 1026 Stoll Place			of. Zip Code 21225			10g. Cit	izen of What Co	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show striplying or other treumatic event, the Medical Examiner must be notified at once.	by Funeral Director		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2√ No If Yes, Give A Year or Dates:	S. 13. Was	Decedent of His	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, Whit Specify:	
21215-0036	filed within 72 ho Hygiene. Ither then *neturi Int, the Wedical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	16a. Decedent's (Give kind life. DO N	of work done di IOT use retired)	urina most of wor	king	16b. K	ind of Business	Industry
pu	should be filed and Mental Hygie marked other umatic event, It	To Be C	17. Father's Name (First, Middle, Last) John Peter Van Do	0				nez Bea	, Maiden sley	Sumame)	7. 0.41
	1 and 2 sho Health and i em 27 is me ther treums		Janice Marie Blau	velt/Sister	521 Do	ver Roa	nd Number or Ru d Glen	Burnie	, MD	21061	
Baltimore,	Pages 1 nent of H ant: If ite ary or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State	lace of Disposition emetery, crematon tro Crem	y or other place		7 - 04		cation - City or timore,	
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Euparal Service Licens Thomas Grego	her	22 Na Cr 29	emation Frede	s of Facility Society rick Roa	of MD, d Bal	Inc timo	re, MD	21228
760,	Physician /Medical Examiner points://enside.	cal Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	n/nunc ()	leficien	ncy Viv	-05			Interval Between Onset and Death 2 days 5 years
	The law requires that the death certificate be exite has been signed by the attending physician age 2 should be detached for use as the buria	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnal 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 □Ecto	opic pregnancy er (specify)				23d. Date of del Month	ivery Day Year
ds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the under	ying cause give	n in Part I.	23e. Did t		use contribute to	the cause of death?
		Completed						24a. Was auto perfo 1 🗀 Yes		prior to death?	itopsy findings available completion of cause of 2 No
f Vital	× 20 0	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	lospital: Inpatient 2 🗆 I	ER/Outpatient 3	□ DOA Othe	26. Place of Dea	th (Check only o		6 □Other (Spe	cify)
ion of	ting After fune		27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury Work 4 1 🗆 Y	at ? ′es 2 □ No	28d. Describe	how inju	ry occurred	
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director. After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street,	actory, office		28f. Location (City or To	Street an wn, State	nd Number or Ru e)	ıral Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occition and/or investi	urred at the tim- gation, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) date and) and manner as d place, and due	stated. to the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier			29c. License				te signed (Mont	
•	X		30. Name and address of person who co					/	poril	23,20	1 21287
	Sta Regist		Scott Stephens MD (31. Date filed (Month, Day, Year) APR 2. 7 2004	32. Registrar's Signal		ins Hopki	ns itespital	Bulh	ncire,	miryland	1 21287

			1 - For State Registrar	State of Mar		epartment of F Certificate of			iene .g. No. 200	13200
	Physici		1. Decedent's Name (First, Middle, Las HELEN	B.		ERSTE		2. Date of Deat Month	h Day Yee	
	/Medic Examir		4a. Fecility Name (If not institution, give			4b. City, Town, o	or Location of De	ath	4c. County of De	004
3	Funeral Director		5. Social Security Number 6. Security Number 197–24–3680	9x ☐ M 2	71 Yrs. last birthd	Months Days			Year) 9. B	irthplece (State or Foreign Country) ennsylvania
	e Maryland 8a-f show	Director	10a. State 10b. County Maryland Anne A		Oc. City, Town o		hicum			10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	th with the 23a or 2	al Dire	10e. Street and Number 323 Regency	Circle		10f. Zip Code 210	90	10	0g. Citizen of What (
980	be filed within 72 hours after death with the Maryland tal Hygiene. Identify then "natural", or Items 23e or 28e-f show avent, the Medical Examiner must be netitied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	er in U.S.	3. Was Decedent of hilf Yes, specify Cub 1 Yes 2 No		(Specify Yes or No- erto Rican, etc.)		nerican Indian, nite, etc.
21215-0036	filed within 72 hc Hygiene. other than "natur ent, the Med Fall	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(G lif	ecedent's Usual Occup live kind of work done e. DO NOT use retire egistere	during most of w d)	vorking	Nursi	,
Maryland 2	should be fited within and Mental Hygiene. marked other than umatic avent, me M	To Be C	17. Father's Name (First, Middle, Last) Joseph Woznia	k	1	CGIDECIC	18. Mother's N	ame (First, Middle, M	faiden Sumame)	ng.
lary	2 a a a	F	19a. Informant's Name/Relationship (T)		19b. M.	ailing Address (Street				Zip Code)
Baltimore, M	es 1 an of Heal fitem 2 r other		August Carl Winter 20a. Method of Disposition 1 Burial 2 MCremation 3 If 4 Donation 5 Other (Specify,	Removal from State	20b. Place of Discemetery, of	Resency sposition (Name of crematory or other plane)	сө)	Date 2	20c. Location - City of	r Town, State
Baltin	permit. Pag Department Important: I any injury o		21. Signature Funeral Service Dicense Edward A. Greg	gorchik		rematory, ² CPemat186 299 Frede	ss Societ erick Ro	y of MD, I ad Baltimo	re, MD 21	
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	DIOGE		SHOC		st,	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	DIOM	YOPOTH ARTE		DISEAS	E.	10 years
,0928	death certificate be executed e attending physician and id for use as the burial-transit	dlcal	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):	MEL	LITUS			15 years
O. Box 6	death certifi e attending d for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 [4 Pregnant at tim	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	′		23d. Date of de Month	elivery Day Year
s, p	equires en sign ould be	þ	Part II. Other significent conditions co	ntributing to death but r	not resulting in the	e underlying cause giv	ren in Part I.		_	to the cause of death?
	The law ate has b page 2 st	Completed	OF Western de la la la la la la la la la la la la la						ed? prior to death? X No 1 ☐ Ye	
f Vit	Physician: This certifical	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 1 Inpatient	2 ER/Outpat	ient 3□ DOA Oth		eath Check only one Home 5 Resider		ecify)
Division o	ding h. After fune	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injur	y Wor	v at	28d. Describe how		ca.y)
=	in the contract of the contrac	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (Specify)	•		City or Town,		
	ne Hospital n 24 hours a ne Funaral E	edical	29a. Certifier (Check only one)	rsician: To the best of n iner: On the basis of ex and manner stated	amination and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occ	ce, and due to the car curred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
)	To the I within 2. To the I complet	W	29b. Signature and title of certifier		1D	29c. Licensi			d. Date signed (Mon	
-	,,,		30. Name and address of person who co	ompleted cause of deat VDソ HF	h (Item 23a) (Typ 3 R BOR	HOSPITAL	13001 13AL	SHAN JIMORE	OVER S	D 21225
	Sta Registra		31. Date filed (Month, Day, Year) APR 2 7 2004	32. Registrar's	Signature	sarker			,	22,2004 TREET D 21225

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month Year Winstead 4 9:30 PM 21 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mariner Health of Catonsville Bultimore Catonsville If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year **Funeral** Birthplece (State or Foreign Country) 1⊠M 2□F Months Days 215-40-8753 Director 60 11/16/1943 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ?? is marked other than "natural", or items 23e or 28e-f show treumstic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Lansdowne 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 2203 Alletta Ave. Funeral 21227 United States 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health end Mental Hygiene. Important: If them 27 is marked other than "natural?" ~ "--- any injury or other treumatic averaging." 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Meat Cutter Food Service 17. Father's Neme (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Lyman Earl Winstead ပ္ Lena Katherine Wooton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) <u>Karen Lipscomb / daughter</u> 2203 Alletta Ave. Lansdowne, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 4/24/2004 Woodlawn, Maryland of Funeral Vivice License 22. Name and Address of Fecility Ambrose Funeral Home of Lansdown 2719 Hammonds Ferry Rd. Lansdowne, Maryland 21227 23a. Pert1. Enter the disease, or complica shock, or heart failure. List only one death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Sepsis Examiner Due to (or as a consequence of): Physiclan/Medical Examiner Gangrene or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Peripheral Vascular disease Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Decubitus 3 Probably 4 SUnknown 1 ☐ Yes 2 ☐ No Be Completed by Multiple Sclerosis 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? certificate 2 8 No 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Ms. Nursing Home 5 Aesidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death i Director: After the of in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours after To the Funeral Direc completely filled in b 29a. Certifier 15. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Cutorsville MO 21228 Rd redruk Bonnie Lohen 31. Date filed (Month, Day, Year)
APR 2 7 2004 32. Registrer's Signature State Registrar

		•	1 - State of Man	rland / Depa <i>Cei</i>	artment of Health artificate of Death		giene 200L	+ 13202
	Dhusisi		Decedent's Name (First, Middle, Last)			2. Date of Dea	ath Day Year	3. Time of Death
	Physici /Medic		Myrtle Velma Withrow				26, 2004	10:35 A M
1-	Examin	er	4a. Facility Neme (If not institution, give street and number)		4b. City, Town, or Location	of Death	4c. County of Dea	
			Mariner Health Care 5. Social Security Number 6. Sex 7. Age (/	n yrs. last birthday)	Catonsville If Under 1 Year If Under	r 24 Hrs. 8. Date of Birt	Baltin	
	Funeral Director		5. Social Security Number 216-34-9013 6. Sex 1 ☐ M 2 🖾 F 6		Months Days Hours	7 24 Hrs. 8. Date of Birt Min. (Month, Da		nthplace (State or Foreign ountry)
	Q		Usuel Residence of Decedent			Todais O	13 17571 116	-
	ehow	_	Maryland Baltimore	c. City, Town or Lo Lansdo				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	Funeral Director	10e. Street and Number	Lansac	10f. Zip Code		10g. Citizen of What C	
	with	급	625 Washington Ave.			ŕ		
	ns 23	era	11 Marital Status 12. Was Decedent Eve	r in U.S. 13.	21227 Was Decedent of Hispanic Orlf Yes, specify Cuban, Mexical	rigin? (Specify Yes or No	U . S . A	erican Indian,
9	or Rec	필	1 Never Married 2 Married 1 Yes 2 No		If Yes, specify Cuban, Mexica 1 □ Yes 2 % No <i>Specify</i> .			
9	ours :	d by	3 ₩ Widowed 4 Divorced If Yes, Give Year or Dates:		TEL THIS ZXEINO SPECIFY.	•	Specify:	White
7	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or flems 23e or 28e-f ehow wit, the Medical Examinational be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during mos DO NOT use retired)	st of working	16b. Kind of Business	s/Industry
12	withir ene. then	E C	Elementary/Secondary (0-12) College (1-4or 5+)	Homem			Own Home	
2	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Rems 23e or 28e-1 ehow event, the Medical Examirar must be notified at	Be C	17. Father's Name (First, Middle, Last)	Homen		er's Name (First, Middle,		
<u>a</u>		To B	Unknown		Mar	garet (maide	en unknown)	
Maryland 21215-0036	s 1 and 2 should be f Health and Menta Item 27 le marked other traumatic ev		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Numb			Zip Code)
	rt z	(3,	Donald Withrow, son		Washington Av			227
altimore,	00		1 XBurial 2 Cremation 3 Removal from State		matory or other place)	Date	20c. Location - City of	
≣	t. Pag tmeni tent: njury	١,				04-27-04	Glen Burni	e, MD
Bal	permit. Pages Department of Importent: If It eny injury or on once.		21. Signature of Funeral Service Licensee	Ä	Name and Address of Facili mbrose Funera. 719 Hammonds	I Home of La	ansdowne	MD. 21227
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each tine.					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	me el	in beant	harly	n	Opset and Death
	/Medical		resulting in death) Due to (or as a continuo	onsequence of):		0/ ()	-	777
	Examiner		Sequentially list conditions, b.	Mion	a rew	1/ por le	irl	5 yes
	ed sit	Examiner	Sequentially list conditions, if any, leading to miniediate cause. Enter Underlying Cause (Disease or injury	unsequence of):				,
•	xecut and	xan	that initiated events resulting in death) Last Due to (or as a c	onsequence of);				
760	ate be executed hysician and the burial-transit	calE	d					
89	tificati ig phy as the						-01:00	
Box	leath certific attending p	Physician/Med	tF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2		∃Ectopic pregnancy		23d. Date of de	
	e deat	sicle	in the past 12 months? 1 Yes 2 No 9 Unknown		Other (specify)		Month	Day Year
о. О	nat the de d by the a letached	Phy	9 Unknown Part II. Other significant conditions contributing to death but if	ant requiting in the co	adah ing asusa susa in Part	1 230 Didte	bbacco use contribute t	a the cause of death?
S,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death out i	or resulting in the u	nderlying cause given in Part	1 236. 010 10	-	robably 4 Unknown
Records,	w require been si	Completed				24a. Was	an 24h Were a	utopsy tindings available
Re E	he lav e has	фшо				autop perfo	sy prior to death?	completion of cause of
Vital	ician: Th certificate rector. pag	Be Co	25. Was case referred to medical		26 Place	1 ☐ Yes e of Death (Check only o	2 No 1 Yes	s 2□ No
\leq	Physician: The riths certificate hirral director, page	0	examiner? 1 ☐ Yes 2 ☐ No Hospitat 1 ☐ Inpatient	2 ER/Outpatier	Tax Care	ersing Home 5 Resid		ecify)
0	ng Ph ter th neral	J: L	27. May r of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Y	28b. Time o			now injury occurred	
<u>S</u>	Attending in death. • ctor: After by the fune	catle	2 Accident investigation		M 1 ☐ Yes 2 ☐			
Division of	I or Attending Paffer death. Director: After ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of thury building, etc. (At home, tarm, str Specify) 	reet, factory, office	28t. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
	pital ours a eral [29a. Certifier 12 Cartifying Physician: To the best of r	ny knowledge, deat	h occurred at the time, date at	nd place, and due to the	cause(s) and manner a	e etated
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check on A Madical Exeminer: On the basis of exemple)	amination and/or in	vestigation, in my opinion, dea	ath occurred at the time,	date and place, and du	e to the cause(s)
	To the To the Complex	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)
)				Who c.	n 129	769	4/27	104.
	7	-	30. Name and address of person who completed cause of deal	h (Item 23a) (Type,	Print)	11121	(10 1	Bylo
	V		morreline V) /	Swern	· (w) 5	(60. 60)	ling lof	M 2028
	Sta Registi		31. Date filed (Month, Day, Year) 32. Refristrar's	oignature				
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 🛭 🖺 👢 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Katherine Waltrup 6:15A^M April 24, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8317 Apt. D Nunley Dr. Baltimore Parkville
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Jan. 12, 1 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 214-03-7149 87 **Director** 1917 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director MD Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "neturel", or Items 23a 8317 Apt. D Nunley Dr. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature" any injury or other transmission. 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Henry Ulrich Leona Anna Warsman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 Topaz Road Baltimore, MD 21234 Bonnie W. Chaustit/Daughter 20b. Place of Disposition (Name of Dulaney, Committee)
Dulaney Valley
Memorial Gardens April 24, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Timonium, MD Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Funeral Service Licens Machael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2XNo ione 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed 1 Yes ≱ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) in by t 4 - Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 cause of death (Item 23a) (Type, Print) OGERARO Abel 214 TIMORIUM 70

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

7 2004

32. Registrar's Signatule

			1 - For State Registrar	te of Maryland / Dep Ce	partment of Health and lertificate of Death	Mental Hygie		4 13201
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Media	al	William A. Webb, Jr. 4a. Facility Name (If not institution, give street a	-	25 2004			
	Examin	er	10603 Lancewood Rd.	h	4c. County of Dea Baltimor			
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthda)	Timonium J If Under 1 Year If Under 24 Hrs	8. Date of Birth		
	Director		267-01-6460 1X M 25	□ F 82 Yrs.	Months Days Hours Min.	Jan. 27	1922	thplace (State or Foreign ountry)
	p .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation			Land Indian Cit. III II
	fanyle faho	ŏ	MD Baltimore	Timoniu				10d. Inside City Limits 1 ☐ Yes 2 No
	28a-	Director	10e. Street and Number	Timorna	10f. Zip Code	10g.	Citizen of What C	
	h with	al D	10603 Lancewood Rd.		21093		USA	
	ems ems	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S. 13 ned Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame Black, Whi	erican Indian,
36	s afte	by Fu	1 Never Married 2 Married 1 If	Yes 2 XNo es, Give	1 ☐ Yes 🎾 No Specify:	7 10211 01017		/hite
altimore, Maryland 21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or Items 23a or 28a-1 show he Medical Evarrhat roust be neitling a	ed p	3 Widowed 4 □ Divorced Yes	ar or Dates:	edent's Usual Occupation	161	o. Kind of Business	
212	nin 72 n. nn "ne Medis	Completed	(Specify only highest grade comp	leted) (Giv life.	e kind of work done during most of wor DO NOT use retired)	king	J. Killa of Dasilless	midustry
7	ad will giene er the	Com			gineer		AAI	
p	be filed htal Hygid od other svent, I	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Mai	den Sumame)	
<u> </u>	should ind Men s marke umatic	은	William A. Webb, Sr.		Margare			
<u>a</u>	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Type, Prii Robert Webb/Son		ing Address (Street and Number or Ru			Zip Code)
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic svent. The Madical Examinet must be neitling at ODCs.		20a. Method of Disposition	20b. Place of Disp	Harrod Ct., Reist		ND 21136 Location - City or	Town, State
ě	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ★ Cremation 3 ☐ Remova `4 ☐ Donation 5 ☐ Other (Specify)	from State	e Wash. Crematory			
ati	mit. partm portm y inju		21. Signature of Funeral Service Licensee	2	2. Name and Address of Facility	Marking Assets		
œ _	Depa Impo any ir		Michael J. Flagle		Lemmon Funeral H O W. Padonia Rd.	lome of Du Timoniu	llaney Va	lley, Inc.
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not er e on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	,	Approximate Interval Between
À	Physician		Immediate Cause (Final disease or condition	atheroschere to	year by			Onset and Death
	/Medical Examiner		resulting in death)	ue to (or as a consequence of):				-
	<u>*</u>	P.	Saquantially list conditions b. D.	ue to (or as a consequence of):				
X	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury					
ó	exec an an			ue to (or as a consequence of):				
3760,	ate be executed obysician and the burial-transit	Ical	d					
3 9	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE:					
Box	leath certific attending p	lan/	in the past 12 months?		Ectopic pregnancy		23d. Date of del	ivery Day Year
P. O.	the de	ysic		Pregnant at time of death 5 Unknown	Other (specify)			
	ires that the de signed by the a I be detached I	by Pt	Part II. Other significant conditions contributin	g to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Vital Records,	w requires been sign should be	ed b	Smoller			1 Ves	2 □ No 3 □ Pr	obably 4 Unknown
ပ္က	e law re has bee je 2 sho	plet	C.D.Y.D -			24a. Was an	24b. Were au	topsy findings available
ř		Completed				autopsy performed 1 ☐ Yes 2 🔀	? death?	completion of cause of
ıta	vician: The certificate hir	Be	25. Was case referred to medical examiner?	-		th (Check only one)		
	Physi this c	2	1 ☐ Yes 2 ☑ No Hospital:	1 Inpatient 2 EN/Outpatie				cify)
u D D	ding l h. After funer	tlon:	1 Natural 5 ☐ Pending	Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Division of	Attendi death. ictor: A iy the fu	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, si		28f. Location (Street	and Number or Ru	ıral Route Number
2	al or / s after I Dira	Certification:	4 Homicide	building, etc. (Specify)	isos, radialy, omod	City or Town, St	ate)	var riobto rioniber,
	Hospital or Attending Physician: 44 hours after death. Furneral Director: After this certificately filled in by the funeral director.		29a. Certifier 1 Certifying Physician:	To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	e(s) and manner as	stated.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Diractor: completely filled in by the	edical	and	the basis of examination and/or in manner stated.	nvestigation, in my opinion, death occur	rred at the time, date :	and place, and due	to the cause(s)
\	To To con	Σ	29b. Signature and title of certifier	Carrie MAN	29c. License number	29d. l	Date signed (Mont)	Day, Year)
	0,		mare u.	COMP 1.	0500		1.50	1
	`		30. Name and address of person who completed			ND 255	20	
	Sta	te	Mark A. Lamos, M.D. 31. Date filed (Month, Day, Year)	32. Registrar's Signature	g Rd., Hunt Valle	y, MD 210	130	
	Registra		ADD 2 7 2004	Grand Po	Sparks!			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 13205 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** IGNATIUS WISSEH April 24 2004 1:30AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Lorien Nursing & Rehab. Center Columbia Howard If Under 24 Hrs. Year Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min. Yrs. Nov.15,1933 Liberia Not Any Director 70 Usual Residence of Decedent filed within 72 hours after death with tha Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No MD Howard Laurel Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9443 Kings Grant Road 20723 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes X ☐ No Specify: Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other traumatic event Be Tatree Toc Kumeh Wisseh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fannon S. Wisseh/son 3 Noa Court, Hackettstown, N.J. 07840 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition # Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem.Gardens05/01/04Marriottsville,MD 22. Name and Address of Facility Witzke Funeral Homes, 21. Signature of Funeral Service Ligensee 5555 Twin Knolls Rd. Columbia, Md. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER /Medical Examiner Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) igned by the attanding be detached for use es 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? cartificate has 1 ☐ Yes 2 ☐ No 1 🗆 Yes ours aftar death.

•rai Director: After this cartificatilled in by the funerel director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Menner of Death 1 Death 2 Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral Completaly filled Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APRIL 26, 2004 00060560

State Registrar

DHMH 16 Rav 6/95

Back River

Neck Rd.

BALTIMORE, MD

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PANKAJ KHETER PAL
31. Date filed (Month, Day, Year)

APR 27

201-109

32. Registrar's Signature

amend item#5, per FH, G844, 6/28/05 TT
State of Maryland / Department of Health and Mental Hygiene? () () () Department of Health and Mental Hygiene [] [] [13206 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Martha Marie Wilson 21 2004 2:15 p /Medical April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Homewood-Crumland Farms Frederick
If Under 1 Year | If Under 24 Hrs. Frederick 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 200€ Months Hours Director Yrs. 83 07/29/1920 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or itams 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD Frederick Frederick 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 7407 Willow Drive U.S.A.

14. Race - American Indian,
Black, White, etc. 21702 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Or 1 1 ☐ Yes 2 ☐ Xio Specify: White Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hair Care 2 Years 7 is marked othe traumatic event, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Meiden Sumame) should be find Mental I Wilhem Ragner Avis Adams Lepa Trand 2 sho more amont of Health and M. Important: if item 27 is ma-any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Clayton, Personal Rep. 6293 Iverson Terr. So. Frederick, MD21701 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 \(\mathbb{R}\) Burial 2 \(\subseteq \text{Cremation} \) 3 \(\mathbb{R}\) Removal from State \(\frac{4}{3} \) Donation 5 \(\subseteq \text{Other} \) (Specify) Sunland Mem. Park 04/27/2004 Sun City, AZ 22. Name and Address of Facility 5555 Twin Knolls Rd. Columbia 21. Signature of Funeral Service Licencee 7 Witzke Funeral Homes, Inc. Maryland 23a. Part1. Enter the disease, of shock, or heart failure. List complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YEALL 12 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit Due to (or as a consequence of): Physician/Medical the as IF FEMALE: igned by the attendin be detached for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Rknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Was cash referred to medical 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) examiner! Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA | Other: 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred of or Attending Parter death.

Birector: After t Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel of within 24 hours at To the Funerel D completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) spe 16428 30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print) Casper E. Cline, M.D. 300 W. 9th Street, Frederick, MD 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 7 2004 Registrar

T.O.D

physician

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Year :54AM 13 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia 8. Date of Birth Sept II, 1939 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country)
 Unk 5. Social Security Number **Funeral** Months 1⊠M 2□F 64 223-03-2240 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show MD Howard Columbia 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 2 eny injury or other traumatic event, the Medical Examiner countries. 21045 9316 Pillar Court USA Completed by Funeral unk 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No un Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No Yes Give Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) unk College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard County General Hospital Little Patuxent Pkwy & Cedar Lane Columbia, Md 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 🛣 Other (Specify) in state 21. Signature of Funeral Tryice Licensee ROM S. Wade, State Anatomy Board 655 W. Baltimore Street Director enien Baltimore, MD 21201 Part 1. Enter the disease, of combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Guse (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 2⊠ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 X R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier ABEDA ROAD, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIDGE HICKO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 🛭 🕦 👢 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 24, 2004 **Physician** Beulah E. Zimmer 5:10 a. M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sun Rise of Pikesville Pikesville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 14, 1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2F 215-07-8414 94 Yrs. Maryland Director Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes XXNo Maryland Baltimore Pikesville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 Church Lane 21208 238 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned 5 Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: by 3 Widowed 4 ☐ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper U. S. F. & G. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 Is marked of r traumatic ever Pages 1 and 2 should be Herbert G. Bowen Lottie Marshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any injury or other trau once. John Rohde (Nephew) 1118 Chatterleigh Circle, Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery April 27, 2004 Pikesville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Oring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee 8728 Liberty Rd. Randallstown, MD 21133-4784 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a confidence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ⊕tinknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 ☐ Yes 2 □-N6 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ño 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide the Hospital Medical 29a. Certifier 1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 19 who completed cause of death (Item 23a) (Type, Print) (e) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1400 Apri 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner land University Mary Cit imore 0 If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 M 2 S F 19,2004 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be nutified at MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 E. 21st Street permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Manufactural once. 21218 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1X Yes 2□ No Specify: mexican Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be Ava Zavala ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Maryland Hospital 22 S. Greene Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 数 Other (Specify) in state grature of Fun Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ran 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 **Physician** 26 min /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Box 68760 Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy sate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 19, April 9 Unknown 2004 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ≥ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Alatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Telesco MID MD 51501 31. Date filed (Month, Day Year) APR 2 32. Regisar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 00 l 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2004 1637AM 08 Charles Leon ALEXANDER, Jr. Ori /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. Director 39 1964 Mary Tand 220-92-1401 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Erant are Intust Le notified at Once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Pennsylvania Franklin Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3537 Barr Road 17225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 Mechanic Auto Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ္က Charles Leon Alexander, Sr. Iona Virginia Turner 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle R. Alexander - Wife 3537 Barr Road Greencastle, Pennsylvania 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | 4/13/04 Hagerstown, Maryland 21. Sign Use of Funeral Service Licenses 22, Name and Address of Facility Minnich Funeral Home MCA15 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORDNAPON 2 weeks /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 1 Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Whitnown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Intury 5 Pending within 24 hours after death.

To the Funeral Director: A М 1 TYes 2 □ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and little of cer 29c. License number 29d. Date signed (Month, Dey, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) EVD SMITHSBURE, 22911 Jefferson 32. Registrar's Signature State Registrar

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Ī	Physicia	an	Decedent's Name (First, Middle, Last)		· · · ·				2. Date of Deat Month		Year	3. Time of Death
	/Medic Examin	al	Donald Charles Barkdoll 4a. Facility Name (If not institution, give street and number)		4b. City.	Town, or	Location of					1000 AM
	Examin	er	Washington County Hospital				agers				Vashin	gton
	Funeral Director		5. Social Security Number 202-20-4547 Usual Residence of Decedent	irthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, April 8,	Year) 1927	9: Birthpl Count Mary	
	nyland how		10a. State 10b. County 10c. City, Tov	wn or Lo	ocation						10	Od. Inside City Limits
	he Ma 28a-f s	ecto	Md. Frederick Smithsburg 10e. Street and Number 10f. Zip Code					1 ☐ Yes 2 No				
	3a or	l Dir	3048 Black Rock Rd.		101. Zip	Code	2178	3			J.S.A.	try?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinatorial be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Nidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates:		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto i	cify Yes or No- Rican, etc.)	Bla	ce - America ack, White, e fy: Whi	etc.
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<u>d</u> 2	illed v Hygie othar t	Be Co	17. Father's Name (First, Middle, Last)		raint		18. Mothe	r's Name	(First, Middle, N		omes	
ylan	Mental Mental arked atic ev	To B	George W. Barkdoll						Macken			
Maryland	id 2 shalth and 27 is m								Route Number, nithsbur			
Baltimore,	Pages 1 ar ent of Hea nt: If item ? ry or othar	1	20a. Method of Disposition 1VRurial 2 Corporation 3 Permoval from State cemete	of Dispo		e of her place	9)	Apr	il 14,	20c. Location Wolfsv	- City or Tov	wn, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service License		2. Name and avis I			ome	12525 Br Smithsbu	adbury	Ave. 2178	3
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, ,	ابرا		30. Name and address of person who completed cause of death (Item 23a)	(Туре,	Print)	U .	174.	13		PITIC	-	2004
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	** * *		Registrar 1. Decedent's Name (First, Middle, Last))				2. Date of Deat	eg. No. h	3. Time of Death		
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	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	119111	4c. County of			
П	=	J.	Avalon Manor			Hagerstov	vn		Washin	gton		
	Funeral		Social Security Number 6. Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02/13/19	Year)	Birthplace (State or Foreign Country)		
	Director		107-03-8936	XM 2□F	86 Yrs.			02/13/19	918	NY		
	and www		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
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	3a or	Ö	1062 Bramly Drive			21742			USA			
	death I s 2	nera		12. Was Decedent E	ver in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp	ecify Yes or No-	14. Race -	- American Indian,		
9	or Ite	Ful	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No. If Yes, Give	0	ir Yes, speciny Cuban 1 □ Yes 23X No	Specify:	rican, etc.)		White, etc. White		
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21215-0036	iit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland criment of Health and Mental Hyglene. crient: If item 27 is marked other than "natural", or items 23a or 28a-f show njury or other treumatic event, I're Modical Examinant must be multiled at a	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of work	ing	16b. Kind of Busi	ness/Industry		
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ē,	Hea Hem tem		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	, -	Date 2	20c. Location - C	ity or Town, State		
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If item 27 is any injury or other tre		1 X Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		en Cemeter		1/2004 I	Japareto	wn MD		
≣	permit. F Departm Importer any injui		21. Signature of Funeral Service Licens	00, /		2. Name and Address				Funeral Home		
ñ	Depo imp any once		305 N. Potomac Street, Hagerstown, M									
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused						Approximate Interval Between		
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	s that ned b s deta	Completed by Physician/Med	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?		
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	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	Mec	29b. Signature and title of certifier	and manner Stat		29c. License	number	29	d. Date signed (Month, Day, Year)		
	ν Σμέβ) -cont 1	No		D (8	019			5, 2004		
	11.7		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Tyne	Print)				` _ ` `		
,	24		Vasant Datta, MD.	340 Mill			MD 2174	0				
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 10 14 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hobert Bare March 12, 2004 9:45P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14422 Ridenour Rd. Smithsburg Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Country) | Months | Days | Hours | Min. | July 1, 1930 | North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 MM 2□ F 237-42-8690 73 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner hust be notified at Md. Frederick 1 ☐ Yes 2 No Smithsburg Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14422 Ridenour Rd. 21783 or Items 23a U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White by 3 Widowed 4 Divorced Year or Dates "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, the Monte. Construction Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dola Bare Bessie J. Dillard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ocie Bare (Wife) 14422 Ridenour Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State March 16, Brown Cemetery Foxville, Md. □Donathon 5 □ Other (Specify) 2004 21 Signature of Jun 1945 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 connes Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** manth Metastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Friter Indanying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): the burial-P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ After this 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 2 Accident Injury 5 Pending after death.
I Director: Aff 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours after To the Funeral Direct Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DJU57600 15/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) con Biva Smithing MD. 31. Date filed (Month, Pay, 32. Registrar's Signature Registrar

			1 - For State Registrar	State of Ma	rylan		artment rtificate			ind Me		giene Reg. No.	C O C) 4	13215
	Physici		Decedent's Name (First, Middle, Last Orlando Thomas I							1	2. Date of De Month	ath Day		Year OD4	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give				4b. City, T	own, or	Location of	f Death	HPRIL	4c.	County of		دراص
	LXAIIII	iei ·	Peninsula Region	al Medica	1 0	wher		5	2/1564	114			W	icon	1100
	Funeral		5. Social Security Number 6. S	ex 7. Age ⊠M 2□F	(In yrs.	last birthday)	If Under 1 Months	Year Days	If Under 2	24 Hrs. 8	B. Date of Birt (Month, Da	th y, Year)	9	9. Birthpla Countr	ce (State or Foreign
	Director		221-16-0277 Usual Residence of Decedent	Z 7	5	Yrs.					Feb. 2			Maryl	
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation	•						100	d. Inside City Limits
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	r dea	ner	11. Marital Status	12. Was Decedent E Armed Forces?		.S. 13.	Was Decede	ent of His	spanic Orig n, Mexican,	in? (Spec Puerto R	ify Yes or No ican, etc.)	-	14. Race - Btack,	American White, et	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 7 ☐ Divorced	t ☐ Yes 2 ☐ N If Yes, Give	0		1 ☐ Yes 2X	□ No	Specify:				Specify:	1	
9	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Eva rifret must be notified at	edt	15. Decedent's Ed	Year or Dates1	121-	16a. Dece	dent's Usual	Occupa	ıtion			16b. Ki	nd of Busi		ack strv
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nd	12 should be filed within "h and Mental Hygiene." 7 Is markad othar than "fraumatic evant, tha Me	Be	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (First, Middle,	Maiden	Sumame)		
<u>\</u>	Men Men Marka Marka	2	Elijah Bowen							ha Pu					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if itsm 27 is marked other than "natural", or flams 23a or 28a-f show any injury or other traumatic evant, the Medical Evandres must be notified at once.		19a. Informant's Name/Relationship (Route Numbe				•
	of Health of Health litsm 27 l		Sierra Bowen/grand 20a. Method of Disposition	daugnter	20b. F	Place of Dispo	sition (Name	e of	- 1	Da	Salisbu te		Cation - Ci		
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Baltimore,	permit. Pag Department Important; I any injury o		21. Signature of Funeral Service Licen		Dt.							Ros	lin, N ad -	Maryı Salisl	bury, MD
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	/Medical Examiner		resulting in death)	Due to (or as a	conseq	uence of):		- +	^						
	.Examine:		Sequentially list conditions,	b. (000	Mur	7 1	rtery	7	115.						
	ted sit	nlner	Sequentially list conditions, if a y, leading to infinity or cause. Enter Underlying Cause (Disease or injury	Oue to (or de s	Feoreeq	uence or):	/								
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	dlcal		d.											
9	tificate ig physi as the	ledle													
ŏ	death certifica attending ph d for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pred	ananev				2	3d. Date o	-	
Э.	the att	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at t			Other (spec						Month	n Da	ay Year
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			For State Registrar	State of Maryland	/ Departme	nt of Health and te of Death		piene 2004	13216
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	Funeral Director			ospital Sex 7. Age (In yrs. las 119M 2□ F 5 5	st birthday) If Und Months	Easton er 1 Year If Under 24 F s Days Hours M	in. 8. Date of Birth (Month, Day)	Talbot (Year) 9. Birth, County	place (State or Foreign
	death with the Maryland ims 23a or 28a-f show	ector	10a. State 10b. County 10e. Street and Number	10c. City,	Town or Location Praksbi	UCS 3682	Idlew	ing. Citizen of What Cou	10d. Inside City Limits 1 Ø Yes 2 □ No ntry?
rd 16		Funeral Director	3682 Jd/ 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	1	21632 edent of Hispanic Origin? eacify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black White,	
Ballar 215-0036	within 72 hours after ene. than "natural", or its the Medical Exercites	Completed by	3 Widowed 4 Dervorced 15. Decedent's E (Specify only highest g.	If Yes, Give Year or Dates: Education rade completed) College (1-4 or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of tuse retired)	working	Specify: B	ack
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	les 1 and 2 sho of Health and I if item 27 is ma or othar trauma		19a. Informant's Name/Relationship Rhanda Ball 20a. Method of Disposition	ard Daugher	19b. Mailing Addre	ess (Street and Number or Carty 1) 2 Iame of r other place)	Rural Route Number Dr. France	1 ~~ 1	702
Arlie Baltimore	permit. Pages Department of Important: If it any injury or o		1 1 1 2 Gremation 3 14 □ Donation 5 □ Other (Special Signature) Fig. 12 15 □ Other (Special Signature) Fig. 12 16 □ Other (Special Signature) Fig. 12 17 □ Other (Special Signature) Fig. 12 18 □ Other (Special Signature) Fig. 12 19 □ Other (Special Signature) Fig. 12 19 □ Other (Special Signature) Fig. 12 19 □ Other (Special Signature) Fig. 12 10 □ Other (Special Signature) Fig. 12 11 □ Other (Special Signature) Fig. 13 12 □ Other (Special Signature) Fig. 13 13 □ Other (Special Signature) Fig. 13 14 □ Other (Special Signature) Fig. 13 15 □ Other (Special Signature) Fig. 13 16 □ Other (Special Signature) Fig. 13 17 □ Other (Special Signature) Fig. 13 18 □ Other (Special Signature) Fig. 14 19 □ Other (Special Signature) Fig. 15 19 □ Other (Special Signature) Fig. 15 10 □ Other (Special Signature) Fig. 15 10 □ Other (Special Signature) Fig. 15 10 □ Other (Special Signature) Fig. 15 10 □ Other (Special Signature) Fig. 15 10 □ Other (Special Signature) Fig. 15 10 □ Other (Special Signature) Fig. 15 11 □ Other (Special Signature) Fig. 15 12 □ Other (Special Signature) Fig. 15 13 □ Other (Special Signature) Fig. 15 14 □ Other (Special Signature) Fig. 15 15 □ Other (Special Signature) Fig. 15 16 □ Other (Special Signature) Fig. 15 16 □ Other (Special Signature) Fig. 15 16 □ Other (Special Signature) Fig. 15 16 □ Other (Special Signature) Fig. 15 17 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig. 15 18 □ Other (Special Signature) Fig.	ity) Tinle	y Chapte 1 2 Name	and Address of Facility		riffnne, M oi Bennie Smit	IL F/H
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Divís	Hospital or Atte 24 hours after des Funaral Directo stely filled in by th	al Certification;		d building, etc. (Specify) Physician: To the best of my know	rledge, death occurre	ed at the time, date and pl	City or Tow ace, and due to the c	cause(s) and manner as	stated.
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	Sta	to.	30. Name and address of person wh	o completed cause of death (item:	R. mD		dlewil	d Ave. Ex	95ton mo
	Registr		31. Date filed (Month Day, Year) APR 12	2004 Deneral	PA	ooils			

State of Maryland / Department of Health and Mental Hygiene, For Stata Registrar 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 30, Patricia S. Buchanan 2004 9:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Days Yrs 579-46-1030 Director 68 09-09-1935 Washington, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28e-f show the Medical Examinan must be notified at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 323 Londontown Rd. 21037 USA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than *r Elementary/Secondary (0-12) College (1-4or 5+) MD District Court 12th Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emory T. Steffey Marion Hitchcock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If item 27 is Stephanie B. Colburn/ Daughter 403 Vale Rd., Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. injury or * 4 □ Donation 5 □ Other (Specify) Lakemont Cemetery 4-2-04 Davidsonville, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 VW 1 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VENTRICULAR **Physician** FIBRILLADON 1ASYSTOLE /Medical Due to (or as a consequence of) Examiner DISEASE ORONAR TE S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Year ō Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? MORBID OBES 24a. Was an has page 2 autopsy performed this certificate 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred t edical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 9 DOA Certification: To 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Hospital 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 038328 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary R. Clance, M.D. 205 Ridgely Ave., Annapolis, Maryland 21401 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 1 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 0 0 L For State Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Month . Tregore 04 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 10420 CLEARY LANE MITCHELLVILLE PRINCE GEORGE'S 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Director 191 44 1391 JAN.20,1929 GREECE Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 289-f show r then "naturel", or items 23e or 28e-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo PRINCE GEORGE'S MARYLAND MITCHELLVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10420 CLEARY LANE 20721 UNITED STATES Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 0 TAILOR CLOTHING Department of Health and Mental Hygie Important: If item 27 Is marked other ten eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAVVAS BAKALIDES KATHERINE DIAMANDOPOULOS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIRMATENIA BAKALIDES (WIFE) 10420 CLEARY LANE MITCHELLVILLE, MD. 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - Cîty or Town, State 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State ST. DEMETRIOS CEMETERY 03-31-04 1 4 ☐ Donation 5 ☐ Other (Specify) ANNAPOLIS, MD. 21. Signature of Forefal Septemblicen permit. 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition AWCDENTIC **Physician** CHUCER mos resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and physician ar s the burial-ti Due to (or as a consequence of) Box 68760. Physician/Medical as attending esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Year 4□Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 1 No 3 Probably 4 Unknown as been signal 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No certificate ha To the Hospitel or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours at To the Funeref D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D18219 MA

Registrar DHMH 17 Rev 1/2001

State

30. Name and address EPHEN

31. Date liled (Month, Day, Year) MAR 3 1 2004

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CAL CARGO

person who completed cause of death (Item 23a) (Type, Print)

ar's Signature

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32. Reg

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Emma Estelle Beavers 24,_ Mar. 2004 9:25 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis ElderCare Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 21X F 92 216-42-9101 18,1911 Apr. Director MD Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene.

marked other than "natural", or froms 23a or 28a-f ehow imatic event, the Medical Examiling found by 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Arnold 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Spotclub Road 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) it. Pages 1 and 2 should be it rtment of Health and Mental I Arthur N. Fleagle Emma V. Cuddy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 is n William C. Smith/Son 107 Spotclub Road, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar. 29, 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. Arnold, MD Asbury Meth. Cemetery * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only bine cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed by the attending physician and tached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ pe been signature 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed this certificate har ral director, page 1 ☐ Yes 2 No 2 DNO 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 2 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident M 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item, 23a) (Type, Print) M. Versville, M.)

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year) MAR 2 9 2004

Division of Vital Records, P.O. Box 68760,

8601

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32. Registrar's Signature

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AMEND23A 3/29/04 State of Maryland / Department of Health and Mental Hygiene 2 1 1 13220 For APPINIZAR 3/29/04 State of Maryland State Registrar AACO HEALTH DEPT. PER PHY. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:51 A M Kenneth 26, 2004 Brooke. March /Medical Sr. 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2605 Chapel Lake Drive Gambrills Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 Q M 2 □ F Hours 85 112-01-1346 June 29, 1918 New York Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f ehow Examiner must be notified at 1 Yes 2 No Directo Maryland | Anne Arundel Gambrills 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with 2605 Chapel Lake Drive 21054 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Affred Forces: 1 X Yes 2 □ No If Yes, Give Year or Dates: 1942-1955 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) Washington Representative 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Shell 0il Coltege (1-4or 5+) Department of Health and Mental Hygiene. Important: If Itam 27 is marked othar than any injury or other traumatic event, Itam Monce. 12 2 For Asiatic Petroleum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Peter Brooke Elizabeth G. Boscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. Brooke / Wife 2605 Chapel Lake Drive, Gambrills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland Veterans 3/29/2004 Crownsville, MD permit. 21. Signature of Funerat Service Licens 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tmmediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** neumonia /Medical **Examiner** abeles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine physician and the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Ruse 24a. Was an autopsy performed? Yes 2 No certificate ha Yper-tensive 1 Yes 25. Was cas examiner? eferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Sescribe how injury occurred Certification: After Natural 2 Accident Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0050321 26 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas F. Hattar, MD 2009 Tidewater Colony Drive, Annapolis, Maryland 21401 32. Registrar's Signature 31. Date filed (Month, Day, Year) AR 2 9 State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** KAREN APRIL 3:45 AM ANN BAILEY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 636 LIBERTY ROAD **FEDERALSBURG** CAROLINE 8. Date of Birth (Month, Day, Year)
DEC. 5, 1952 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 1 □ M 2 X F 568-72-2472 51 CALIFORNIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits į 1 ☐ Yes 2 X No MD CAROLINE **FEDERALSBURG**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event. In Medical Examinar must be notified at once. Baltimore, Maryland 21215-0036

Funeral

Director

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760, attending ph s certificate has the inector, page 2 st within 24 hours after death.
To the Funeral Director: After thi
completely filled in by the funeral of

10e. Street and Number		10f. Zip Code		10g. (Citizen of What Country?	
636 LIBERTY ROAD		21632			ISA	
10e. Street and Number 636 LIBERTY ROAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) 12	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of II Yes, specify Cut 1 ☐ Yes 2 ▼ No	Hispanic Origin? (Spec pan, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - American Indi Black, White, etc. Specify: WHITE	
15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual Occu (Give kind of work done	during most of working	16b.	Kind of Business/Industry	
Elementary/Secondary (0-12)	College (1-4or 5+)	SOCIAL SERVICE	ed)		FEDERAL GOVE	RNMENT
17. Father's Name (First, Middle, Last) GLEN E. ABBOTT			18. Mother's Name ((First, Middle, Maide OU LINDLE	,	
19a. Informant's Name/Relationship (Type WYMAN BAILEY/HUSB		19b. Mailing Address (Stree				
20a. Method of Disposition 1 Burial 2 Coremation 3 R. 4 Donation 5 Other (Specify)	emoval from State	ee of Disposition (Name of letery, crematory or other place) APEAKE CREMAT			Location - City or Town, St	
21. Signature of Funeral Service License		22. Name and Addr. FELLOWS . H		& NEWNAM	FUNERAL HOME 21619	, P.A.
23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line. Met. 5 t.2 Due to (or as a consequer	Do not enter the mode of dy	ing, such as cardiac or	respiratory arrest,	Appro Interv	ximate al Between and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequer					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnand	у		23d. Date of delivery Month Day	Year
Part II. Other significant conditions con	tributing to death but not resultin	ng in the underlying cause gi	ven in Part I.		ouse contribute to the caus	
				24a. Was an autopsy performed?		n of cause of
25. Was case referred to medical examiner?	ospital:		26. Place of Death (
27. Manner of Death	I _ Inpatient 2 _ EH	3b. Time of 28c. Inju Injury Wo	ner: 4 Nursing Home ry at 28 rk? Yes 2 No	e 5 X Fesidence d. Describe how inj	6 □Other (Specify) ury occurred	
2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			II. Location (Street a City or Town, Sta	and Number or Rural Route te)	Number,
1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 29b. Signature and title of certifier	icien: To the best of my knowle er: On the basis of examination and manner stated.	edge, death occurred at the ti	me, date and place, an opinion, death occurred	d due to the cause(at the time, date ar	s) and manner as stated. nd place, and due to the ca	use(s)
29b. Signature and title of certifier	ahmer M	29c. Licen:	56 number	29d. D Apr	ate signed (Month, Day, Ye	ear)
30. Name and address of person who con		Deleuns Stre	£1311 m	ce Mory	land 2123	3/

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Магу	Bad	to	MD	Queen An	ne's	Chur	ch H	i11						1 ☐ Yes 2 🙀 N
the	DE L	e e	10e. Street and Nu	ımber				10f. Zip	Code		1(0g. Citizen of W	het Coun	try?
with r	38 01		630 Rabb:	it Hill R	d.			216	623			USA		
r death	er s	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?		S. 13	. Was Deced	ent of I	dispanic Origin? (Specifian, Mexican, Puerto Ric	fy Yes or No- can, etc.)		- America c, White, e	an Indian, etc.
1215-0036 within 72 hours after death with the Maryland	item 27 is marked other than "natural, or flems 23s or 28e-1 show other traumatic event, the Medical Examinal mast be notified at	þ	1 Never Man	ried 2 Married 4 Divorced	1 ☐ Yes 2⁄☐ If Yes, Give Year or Dates:	No		1 ☐ Yes 2	∏ No	Specify:		Specify:	Whit	te
Baltimore, Maryland 21215-0036 Dermit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene.	natur	Completed	(Spe	15. Decedent's E- city only highest gra	ducation de completed)		(Giv	edent's Usua e kind of wor DO NOT us	k done	during most of working		16b. Kind of Bu	siness/Inc	dustry
212 d withir giene.	In M	omo	Elementary/Sec 12	ondary (0-12)	College (1-4or 5	5+)		Farmer				Agricul		
d 2 Hyg	ent,	Bec	17. Father's Name	(First, Middle, Last,)					18. Mother's Name (I)	
ld be	Ic ev	10 B	George 1	Richard B	ostic					Amanda Ire	ne Cah	all		
aryla 2 should and Men	E E		19a. Informant's N	lame/Relationship (Type, Print)	- 1		-		and Number or Rural F				
Malth 2	27 E		Dorothy (C. Bostic	/ Wife	150	630 1	Rabbit	Hi.	ll Rd.,Chur	ch Hil	1, MD	2162	23
ges 1 ar	othe		20a. Method of Dis			. ce	metery, cr	oosition (Name	her pla	ce) Dat		20c. Location -	City or To	wn, State
Page nent o	ant: If			Cremation 3 L 5 Other (Special]Removal from State (y)	sud1	erśvi	ille Ce	emet	ery 4/8/0	4 51	ıdlersv:	ille,	, MD
Balt permit. Departr	Important: I any injury o once.		21. Signature of F	uneral Service Lice	nsee			22. Name and F 1 OW:	d Addre	ess of Facility Helfenbein Rd., Chest	& Newn	am Fune	ral I 21620	Home, PA
	*		shock, or he	art failure. List only	plications that caused one cause on each li	d the death. ine.	. Do not e	nter the mode	e of dyi	ng, such as cardiac or r	respiratory arre	est,		Approximate In rval Between Orset and Death
/Me	sician edical miner		Immediate Cause disease or conditi resulting in death)	ion	a. Shudl Due to (or as	_		lung	C	ancer			-	7 mier
ile —		lner	Esquentially list of if any, leading to ucause. Enter Und Cause (Disease of	immediate deriving	Due to (or as	a consequ	ence of):							
Box 68760, death certificate be executed	g physician and as the burial-transit	al Examine	that initiated even resulting in death)	ts	Due to (or as	a consequ	ence of):			· · · · · · · · · · · · · · · · · · ·				
X 68760, certificate be ex	nding phys use as the	/Medic	IF FEMALE:		23c. If yes, outcome							23d. Date	e of delive	ary
P.O. Box	by the atten tached for u	Physician/Medical	23b. Was decede in the past 1: 1 \sum Yes 2 9 \sum Unknow	2 months?	t □Live birth 4□Pregnant a 9□ Unknown			B □Ectopic pro B □ Other (spo				Mor	ith	Day Year
<u> </u>	gned se de	by	Part II. Other sign	nificant conditions	contributing to death b	out not resu	Ilting in the	underlying c	ause gi	ven in Part I.				ne cause of death? pably 4 Dunknow
e law	cate has been si page 2 should t	Completed									24a. Was a autops perform	med?	Vere autoprior to content?	psy findings availal mpletion of cause o
E !:	cate , pag	ŭ									10163	L (140		

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

215-36-2377

Usual Residence of Decedent

George Raymond Bostic

4a. Fecility Name (If not institution, give street and number)

Memorial Hospital

XXXM 2□F

7. Age (In yrs. last birthday)

72

Physician

/Medical

Examiner

Funeral

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Months

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 1 1

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Days

Easton

2. Date of Death Month

8. Date of Birth (Month, Day, Year)

5-22-31

April

Day

2004

4c. County of Deeth

Talbot

1450

10d. Inside City Limits 1 ☐ Yes 2 ☑ No

Birthplace (State or Foreign Country)

MD

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

10

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify,

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Approximate The and Death to

3,

State Registrar

Be

Certification: To

Medical

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ ¶o

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 T Homicide

Division of Vital Records, or Attending Physician: The law requires

David H. Smith, M.D., 6602 Shurch Hill Road, Chestertown, MD 21620

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - State of Marylan State of Marylan	d / Depa <i>Cei</i>	artment of Health and I rtificate of Death		ene2004	13223
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici		William L.	Brook		March 14	Day Year 2004	7;30 P M
	/Medie Examir		4a. Facility Neme (If not institution, give street and number)	DLOOK	4b. City, Town, or Location of Death		4c. County of Death	
	Exami		Chester River Manor					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	ast birthday)	Chestertown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Kent 9 Birth	ptace (State or Foreign
	Director		163-10-8501 ^{1□} X ^{M 2□} F 9		Months Days Hours Min.	8. Date of Birth (Month, Day, Y	1909 Per	intry)
			Usual Residence of Decedent			may 25,	1909 Pet	nsylvania
	land ow		10a. State 10b. County 10c. Cit	, Town or Lo	cation			10d. Inside City Limits
	Man	jo	MD. Kent	Chog	tertown			1 ☐Yes 2 ☐ No
	1he 28a	Director	10e. Street and Number	Ciles	10f. Zip Code	100	. Citizen of What Cou	Λ
	with					109		ntry
	death with the Maryland ms 23a or 28a-f show	Funeral	200 Morgnec Road 11. Marital Status 12. Was Decedent Ever in U.	C 12 1	21620	7 1	USA	
	Her d	Ë	Armed Forces?		Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White	
36	hours after tural", or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	1	☐ Yes 2☐No Specify:		Specify: TT	
3	hour tural			10+ D	Λ	1 :=		nite
က်	be lided within 72 hours after death with the Marylan tal Hygione. do other than "natural", or items 23s or 28s-f show event, the Medical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usuaf Occupation kind of work done during most of worl DO NOT use retired)	king 16	b. Kind of Business/Ir	idustry
12	withii sne. than	m	Elementary/Secondary (0-12) Cotlege (1-4or 5+)					
7	tygie her 1	ပိ		Cha	auffeur		<u>Publishir</u>	g
ב	d of	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
Maryland 21215-0036	should ind Men marke umatic	ျှ	Howard Brook		Florenc	e May Mac	Mullin	
<u>ಹ</u>	2 should and Mer is marke aumatic	1/ 3	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zip	Code)
_	コモトラ		Florence Brook	400 1	Hadaway Drive Apt	. 4 Chest	ertown Md	21620
ğ	ーエッニ		20a. Method of Disposition 20b. P	ace of Dispos	sition (Name of natory or other place)		c. Location - City or To	
Ë	Pages nent of int: If it		TEAGGIST 2 CONTINUED 3 CHANDASTION 3/4/6			/2004 Fe	o	
			21. Signature of Funeral Service Licensee		Name and Address of Facility	/2004 F	ernwood, P	ennsylvania
n	permit. Departr Importa any inju		1. 1.11	Mi	Name and Address of Facility Irphy-Ruffenack F cd & Wolf Streets	uneral Ho	me .	40410
			23a, part. Enter the disease, or complications that caused the death) Do not coto	α woll Streets	, Philade	Iphia, PA.	
			shock, of heart failure. List only one cause on each line.	. Do not ente	or the mode of dying, such as cardiac	or respiratory arrest,	'	Approximate Intervat Between
F	hysician		Immediate Cause (Final disease or condition	iluve				Onset and Death Mouth
١,	/Medical Examiner		Due to (or as a consequ	ence of):				
	zxammer		Sequentially list conditions by Avtovia Scl	evotic	Cardio Vascular	Diseave		10 years
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):				3
	od nd	Examiner	that initiated events					
s ·	exe an ar rial-t		resulting in death) Last Due to (or as a consequ	ence of):				
04/8	ate be executed physician and the burial-transit	dical	d					
9	death certificate be executed e attending physician and id for use as the burial-transit	40	- U					
ŏ	attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant	ю			23d. Date of delive	201
Ď	atte	cia	in the past 12 months?		Ectopic pregnancy Other (specify)		Month Month	Day Year
5	y the	ysi	1 Yes 2 No 9 Unknown 9 Unknown	u 0	Other (Specify)		i.	
7	been signed by the should be detached		Part II. Other significent conditions contributing to death but not resu	ting in the un	deriving cause given in Part I	23a Did tobac	co use contribute to the	an anuma of death?
Š.	requires that	by						
cords	pen	tec	Afib, CVA, Hx Colon (A, A) 31			1 □ Yes	2 □ No 3E Prob	ably 4 □Unknown
e c	ate has b	Completed by	Coll CA. S/ Bladdor, Arthritis, P	Seud o'	joint, Hx MIE,	24a. Was an autopsy	24b. Were auto	psy findings available
r	ate h	or	,			performed	<pre>1? death?</pre>	nptetion of cause of
VITAI	tor, 1	0	25. Was case referred to medical		26 Place of Deat	h (Check only one)	No I I Tes	2 □ No
>	s ce direc	OB	examiner? 1 ☐ Yes 2 ∰No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	0.0	-	e 6 □Other (Specify	
5	erath brai	H	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury at	28d. Describe how in		//
5	th.	tlo	1. Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Work? M 1 ☐ Yes 2 ☐ No		, , , , , , , , , , , , , , , , , , , ,	
DIVISION	dea ctor	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At hor	ne farm etre		28f Location (Street	t and Number or Rura	I Pauta klumbar
3	Dire	erti	4 Homicide determined 206. Place of Injury - At not building, etc. (Specify,	10, 10,11, 3,10	ot, ractory, orrice	City or Town, Si	tate)	n Houte Number,
	ours eral		29a. Certifier 107 Certifying Physician: To the best of my know					
3	to the troughter or standard priyacters. The late within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Examiner: On the basis of examinati	rledge, death on and/or inve	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as st and ptace, and due to	ated. the cause(s)
4	the mple	Mec	and mariner stated.					
F	₹ ¥ £ 8		29b. Signature and title of certifier		29c. License number		Date signed (Month, I	Jay, Year)
			IN THE CONTRACTOR		\$50996	3	15/04	
			30. Name and address of person who completed cause of death (ftem	23a) (Type, P			22.5	
			Neil Stodaura MD 1	003	rown at line	Stertow	nind	21620
	Sta	_	31. Date filed (Month, Day, Year) 32. Rej strar's Signatu	ire M	hould a			
	Registra	ar	MAR 1 6 2004	N. 16	PART CONTENT			1

Physician /Medica Examiner	Decedent's Name (First, Middle Decedent's Name (First, M	a. Last)			Death	Reg.	NO.	
Examine)X		ALC: T		2. Date of Death Month April 11	Day Year . 2004	3. Time of Death 02:00 PM
		Retirement Vill	.age yrs. last birthday)	Williams	r Location of Death Oort If Under 24 Hrs.		4c. County of Death	n
uneral rector	216-44-2739 Usual Residence of Decedent	40.4 -30.5	76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye July 31, 1	1927 Wash	nplace (State or Foreign untry) nington, D.(
Med at	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 AYes 2 No
3a or 28a	MD Washir 10e. Street and Number 17817 Greentre			10f. Zip Code 21740		10g.	Citizen of What Co	untry?
arked other than "natural, or items 23e or 28e-f show atic event, the Medical Exeminer must be notified at To Re Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marital 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces?		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specity:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White	
than "nature to Maulcal E	15. Deceden		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work	ring	c. Kind of Business/I	
irkad other itic event, it	17. Father's Name (First, Middle,	Last)	AdilLi	IISTIALOI		e (First, Middle, Mai arie Pryo	den Sumame)	erment
7 is m traum	19a. Informant's Name/Relations William P. Your 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation	ag / Executor 3 □Removal from State	82 W.	Washingt sition (Name of natory or other place	ton St. H	10001	MD 2174 c. Location - City or T	O Fown, State
Important: If item 2 any injury or other once.	'4 □ Donation 5 □ Other (S		22	Mem. Par Name and Addres 05 N. Pot	ss of Facility Ge			neral Home
sician edical miner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused the conty one cause on each line. a. <u>Endstage</u> Due to (or as a cor	Parkinso			or respiratory arrest,		Approximate Interval Between Onset and Death Years
	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last	b. Due to (or as a conductor) c. Due to (or as a conductor)						
y the attending priched for use as it	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c, If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
an signed bould be deta	Part II. Other significant condition	ns contributing to death but not	resulting in the u	nderlying cause give	en in Part I.		co use contribute to 2 XNo 3 ☐ Pro	the cause of death?
cate has page 2						24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of 2 No
his certiful director	O 1 ☐ Yes 21 No	Hospital:	2 ☐ ER/Outpatier		ər: 4 🔀 Nursing Ho	me 5 ☐ Residence	e 6 □Other (Spec	ify)
To the Funeral Director: Attert completely filled in by the funera completely filled in by the funeral Medical Certification:	27. Manner of Death 1 XNatural 5 Pendin 2 Accident investig 3 Suicide 6 Could determ	not be 28e. Place of Injury	At home, farm, str	M 1 □ Y	Yes 2□No	28d. Describe how in 28f. Location (Street		ral Route Number.
uneral Dire		building, etc. (Sp	knowledge, deati	occurred at the tim	e, date and place,	City or Town, Si	tate) e(s) and manner as	stated.
To the Fune completely fit	29b. Signature and title of certifie	Examiner: On the basis of exam and manner stated.	milation and/or in	29c. License	number	29d.	Date signed (Month	Day, Year)
1	30. Name and address of person Ted E. Howe M.			D 33 Print) Williamsp			oril 11, 2	004

DHMH 17 Rev 1/2001

Amend Item #5 per fl State of Manual Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 4 lartha Cavanaugh 2004 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Washington Hagerstow M 2110 Manor 8. Date of Birth (Month, Day, Year) March 28,1920 5. 215 16 Links Standard 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 🗓 F Yrs. 84 Maryland Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1⊠Yes 2□No Director Waynesboro Penna. Franklin 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 204 W. Main Street Herns 23a 17268 Funerai filed within 72 hours efter deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 No Specify: Specify: white ģ 3 ☑ Widowed 4 ☐ Divorced "naturel" Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) realtor real estate other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) . Peges 1 and 2 should be fil ment of Health end Mental H tant: If item 27 is marked ott Alice L. Barnhart Paul M. Kreglo, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Health end Important: If Item 27 Is m any Injury or other traum once. Roberta E. Harner - daughter 1522 Kensington Dr., Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/9/04 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility MINNICH FUNERAL HOME 21. Signature of Function Service Licenses ∡415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner hroa attending physician and for use as the burial-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence ol) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ete hes been signed by the a page 2 should be detached 3 ☐ Probably ☐ Unknown 1 ☐ Yes 2 ☐ No ð 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No certificete Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 104 6 00060396 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) MURSHER FARID 31. Date filed (Month, Man Yes 32. Registrer's Signature State Registrar

				1 - For State Registrar	State of Ma	aryland	/ Depa	rtment of F	lealth an <i>Death</i>	d Mental	Hygie	ne 2 ()	0 l4	13226
		Physici	an	Decedent's Name (First, Middle, Last, JOSEPHINE MARJOF		7,				2. Date Monti	of Death	Day	Year	3. Time of Death
		/Medio Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of D	Mare eath	cn 1	1, 20 4c. County		9:50 P™
ine				REEDERS MEMORIAL					BOONSBO					HINGTON
CE		Funeral Director		5. Social Security Number 6. Security Number 214-74-5167	7. Age	88 (In yrs. las	t birthday) Yrs.	Months Days	If Under 24 Hours	Ain. JULY	of Birth h. <i>Day</i> , Ye 26,	1915	9. Birthp Cour N	place (State or Foreign ptry) IARYLAND
6	yland	Mot.		10a. State 10b. County		10c. City,	Town or Loc	eation					1	0d. Inside City Limits
7.6	of the Maryland	39-f s	Director	MARYLAND WASH	INGTON			BOC	NSBORO					1 XYes 2 □ No
100	with th	e or 2 be no		10e. Street and Number	700			10f. Zip Code	1740		10g.	Citizen of V		,
4	Jeath	ns 23	Funeral	141 S. MAIN STREE	12. Was Decedent E	ver in U.S.	13. V		1713	(Specify Yes	or No-	14. Rac		S.A.
Ma	Maryland 21215-0036 d 2 should be filed within 72 hours after or	of Health and Mental Hygiene. Itam 27 is marked other then "naturel", or Items 23e or 28e-f show other traumatic evant, Ita Modical Exercit at Irast be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	o		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 X No	Specify:	uèrto Rican, etc	.)		k, White,	
6	5-0	"natu	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)		(Give I	ent's Usual Occup	during most of	working	16b	. Kind of Bu		
2	121 within	then then	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. D	O NOT use retired	MAKER				OLINI	HOME
sephine	d 2	n and Mental Hygiene. 7 is marked other then ". raumatic evant, It e M.	Be Co	17. Father's Name (First, Middle, Last)				поги		Name (First, Mi	iddle, Maid		OWN e)	HOME
G	/lan	Menta rked tic ev	To B	JOHN F. CLOPPER					BESSI	E MAY BU	JCK			
05	Aar) 2 sho	ls me		19a. Informant's Name/Relationship (Ty	pe, Print)			Address (Street						Code)
1	_	of Health itam 27 t		NATALIE J. MOSE, I	DAUGHTER	20b. Plac		YOUNG AV	ENUE, I	BOONSBOE Date	-	ARYLA Location -		21713
	TOT			1 ☐ Burial 2 X Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cem	etery, crem	atory or other plac G CREMAT						MARYLAND
NAME	Baltimore,	Department Important: I any injury o		21. Signature of Funcial Service Ligense	90			Name and Addres						PIKE
A	m &			RATIVA THIM		5		BAST FUN		ME BUC	NSBU	RO, M		
2				23a. Part1 Enter the discase, or compli shock or hear failure. List only or	cations that caused t	the death.	Do not ente	r the mode of dyin	g, such as card	diac or respirato	ory arrest,			Approximate Interval Between
	45"	nysician		Immediate Cause (Final disease or condition resulting in death)	Br	am	Cew	cer					5	Onset and Death Menth
		Medical xaminer			Due to (or as a	consequer	ice of):							
	ited	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequen	ce of):							
	8760, cate be execut	ohysician and the burial-transil		that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):		··					
	687 ifficate		edicai											
	Division of Vital Records, P.O. Box 6 to Attanding Physicien: The law requires that the death certific	ed by the attending pl detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown	Petal de	ath 3□£	Ectopic pregnancy Other (specify)			_	23d. Date Mon	of deliver	ry Day Year
	ds, P.	signed by Id be detac	d by Ph	Part II. Other significant conditions con	tributing to death but	t not resultin	ng in the und	derlying cause give	en in Part I.		Did tobacc	1 .		e cause of death?
	COL	s been si	Completed	Dex	lise mel nentra					24a. V	Vas an	24b. W	/ere auton	sy findings available
	l Re	ate has page 2	mo							- a p 1 □ Ye	utopsy erformed? es 2	/ de	eath?	sy findings available apletion of cause of
	/ita	is certificate ha	Be	25. Was case referred to medical examiner?						Death Check of	/-	10		
	of \	this c	ပ္	1 ☐ Yes 2 No H	ospital: 1 Inpatient		Outpatient	3□ DOA Othe	Nursing	Home 5 F				
	On	th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28	b. Time of Injury	28c. Injury Work	at ? /es 2 □ No	28d. Descr	ibe how in	jury occurre	ed	
	Divisi	within 24 hours after death. To the Funaral Diractor: A completely filled in by the fe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home (Specify)	, farm, stree			28f. Locatio City or	on (Street Town, Sta	and Numbe ate)	r or Rural	Route Number,
	To the Hospital	n 24 hours he Funara pletely fille	edical	29a. Certifier (Check only one) Certifying Phys 2 Medical Examin	ician: To the best of ler: On the basis of e and manner state	examination	dge, death and/or inve	occurred at the time estigation, in my op	e, date and pla sinion, death or	ice, and due to courred at the tir	the cause ne, date a	(s) and man	ner as sta	tted. the cause(s)
	Tot	To t	Σ	29b. Signature and title of certifier	1	1		29c. License				ate signed		
	•	12							1996		M	anch1	1,20	7 00
	5H			30. Name and address of person who con				*	ן וא אין	and 217	112 /	201 /	122 0	470
		Sta	te	Dr. Zafar Malik 20 31. Date filed (Month, Day, Year)	32. Registrar	's Signaturg	au, D	whi a	, Haryl	anu ZI/	13 /	20.T=v	134-0	-r/U
		Registra		MAR 12 20	MA Reser	a D	· Ly	AL ARREST						

			1 - For State Registrar	State of N	Maryland / De <i>C</i>	partment of e <i>rtificate o</i> i			ene g. No. 2004	13227
			Decedent's Name (First, Middle, L.	.ast)				2. Date of Death		3. Time of Death
	Physici /Medic		Katherine Luc	ille Cup	ernall			marc	Day 2004	4 5:55 M
	Examin		4a. Fecility Name (If not institution, g				or Location of Dea	th	4c. County of Deat	
9			Washington Coun 5. Social Security Number 6.		l⊥ Age (In yrs. last birthda	Hagers		S. 8. Date of Birth	Washing	
12	Funeral Director		087-20-3141	1□M 2⊠F	76 Yrs	Months Day			Year) Co	hplace (State or Foreign untry) NY
	ס		Usual Residence of Decedent						/21	
	aryiar show	_	10a. State 10b. County	ton	Mousens					10d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	MD Washing 10e. Street and Number	LOII	Maugans	10f. Zip Code		10	g. Citizen of What Co	
	with Ba or	Ö	14019 Village M	ill Dr. F4	i	21767			USA	uritry r
	death	nera	11. Marital Status	12. Was Decede	nt Ever in U.S. 1	3. Was Decedent of	Hispanic Origin? (Specify Yes or No-	14. Race - Ame	
စ္အ	or ite	, Fu	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2 [If Yes, Give		If Yes, specify Cu	ban, Mexican, Pue o <i>Specify:</i>	rto Rican, etc.)	Black, White	
003	ural',	d b	3 XWidowed 4 ☐ Divorced	Year or Date						hite —————
7	n 72 n nat	Completed by Funeral	15. Decedent's (Specify only highest g	rade com <i>pleted)</i>	(G	cedent's Usual Occi ve <i>kind of work d</i> on <i>DO NOT u</i> se <i>retii</i>	e during most of wo	orking	6b. Kind of Business/	Industry
212	l with liene.	omo	Elementary/Secondary (0-12)	College (1-4d	or 5+)	artment N	_ ^		Manufac	cturing
פ	be filed within 72 hours after death with the Maryland (at Hyglene) of other than "netural", or flems 23e or 28e-f show event, the Madical Examinat maint be notified at	Be C	17. Father's Name (First, Middle, La	st)	<u> </u>			me (First, Middle, Ma		
ylai	Menti Menti arked	To I	Ernest P. Lovela					ha (unk) S		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Madical Examination mad be notified at once.		19a. Informant's Name/Relationship Christopher P. (ural Route Number, (Stown, MD	City or Town, State, Z ク17ムク	ip Code)
ē,	Healt Healt tem 2 other		20a. Method of Disposition	oapernarr,	20b. Place of Dis	position (Name of			Oc. Location - City or	Fown, State
DE L	Pages enf of nt: If i		1 ☑Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		te	rematory or other pi 1 Cemeter		12/2004 Ha	gerstown,	MD
Baltimore,	permit. Departm Importal any inju		21. Signature of Funeral Service Lic	**	11050 1111				linnich Fu	
<u> </u>	89 = 8		103,4			305 N. Po	tomac St	reet, Hage	erstown, M	21740
15			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	i line.					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a chron		ructive	hing	Disca	52	Oliset and Death
	Examiner		1		as a consequence of):	Hear	r Fai	lurc		
å		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a consequence of):					
	cuted nd ransit	Examiner	that initiated events	c						
, 0	ate be executed hysician and the burial-transit	I Ex	resulting in death) Last	Due to (or a	as a consequence of):					
8760,	icate be executed physician and s the burial-transit	dical		d						
9 x	leath certific attending p	//Me	IF FEMALE:	23c. If yes, outcon	ne of pregnancy				23d. Date of deir	ven.
Вох	death a atter d for L	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant	2 Fetal death at time of death	B □Ectopic pregnan Di□ Other (specify)	су		Month Month	Day Year
P.O.	that the de led by the a detached f	hys	9 Unknown	9⊡ Unknown						
	The law requires that the death certific sle has been signed by the attending p page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause g	iven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	een s	ted						1 ☐ Yes	2 □ No 3 □ Pro	bably 4 DUnknown
Records,	has b	Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
	Physicien: The la rthis certificate has ral director, page 2	e Co	OS Man and referred to medical					1 Yes 2 €	No 1 □ Yes	2 No
5	rsicie s certi directo	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital:	trient 2 ☐ ER/Outpat	ient 3□ DOA O	ther	ath (Check only one)	ce 6 □Other (Spec	is.
100	Attending Physicien: r death. sctor: After this certifics by the funeral director. I	T:U	27. Manner of Death	28a. Date of Ir		of 28c. Inj		28d. Describe how		ny)
Sior	ttendin death. stor: Afi r the fur	atio	1 Natural 5 Pending 2 Accident investigati	on	nijur		TYes 2 □ No			
Division of Vital	i or Attending after death. Director: After in by the funer	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office	9	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	Hospital		29a. Certifier 1X Certifying I	Physician: To the he	st of my knowledge, de	ath accurred at the	time, data and place	and due to the ear		
	To the Hospital or Attending Phwithin 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Expone)	aminer: On the basis and manner	of examination and/or	investigation, in my	opinion, death occ	urred at the time, date	e and place, and due	to the cause(s)
	To the within 2 To the complet	Ĭ.	29b. Signature and title of certifier				nse number		d. Date signed (Month	, Day, Year)
	15		James ?	home		D	006039		40/60/80	
6	*		30. Name and address of person wh	o completed cause o	f death (Item 23a) (Type	e Print)	+ 1	1. Ind.	2/2/62	
9	Sta	te	31. Date filed (Month, Day, Year)		strar's Signatur	1 Caur	i /T	I. Irid. c	21142	
	Registr			2004	sura A. A	journa				

William Carter 215-26-5996 Division of Vital Records, P.O. Box 68760,

			Please '		k Indelible Ink. Ensure	-	_
			1 - For State Registrar AMEND TIEM #23	State of Maryland / E c PER PHY C831 5/13/C	Department of Health and Captificate of Death		ene 2004 13228
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Las. Madle, Las. Middle, Las. Mid	street and number)	4b. City, Town, or Location of Dec	2. Date of Death Month	Day Year 3. Time of Death 18:41 PM 4c. County of Death Williams
	Funeral Director		5. Social Security Number 6. Se 215-26-3996 19 Usual Residence of Decedent	7. Age (In yrs. last bin	thday) II Under 1 Year If Under 24 Hi Months Days Hours Mil		
	h the Maryland if 28a-f show	irector	10a. State 10b. County Md WiComio 10e. Street and Number	10c. City, Town	n or Location Lella Springs 101. Zip Code	21837	10d. Inside City Limits 1
36	be filed within 72 hours after death with the Maryland stal Hygiene. od other than "netural", or Itams 23e or 28a-f show event. It a Medical Exterition frontified at	by Funeral Director	9864 Wallev 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give	21837 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	filed within 72 hour Hygiene. ther than "netural int, I why lice E	Completed b	15. Decedent's Edi (Specify only highest grad	Year or Dates:	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16	St. Kind of Business/Industry Deers Head
Maryland	ed ital	To Be (17. Father's Name (First, Middle, Last) Pe-He 19a. Informant's Name/Relationship (To	er Carter	Vio	ame (First, Middle, Ma	Bride
altimore, Ma	ges 1 and 2: of Health ar if itam 27 is or other trau		Kennth Carter 20a. Method of Disposition 1 Courial 2 Cremation 3 1 14 Donation 5 Other (Specify,	Son Removal from State 20b. Place of cemeter	Mailing Address (Street and Number or F	Salisburg	bennie Smith F/H ac Location City or Town, State
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeyal Service Udens 23a. Part1. Enter the disease, or comp	lications that caused the death. Do n	22. Name and Address of Facility 917 L.). School 1/2 Solution of dying, such as cardia	+ Sclis.	
	Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a	tial Injur	Lion	Interval Between Onset and Death
68760,	e be executed sician and e purial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. VENIRICULAR TAI Due to (or as a consequence of	YCARDIA	NV SI	
O. Box	that the death certificate be exc led by the attending physician a detached for use as the burial-	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. II yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Records, P	The law requires that tte has been signed b page 2 should be deta	by	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to the cause of death?
Vital Rec	(0	Be Completed	25. Was case referred to medical examiner?		26. Place of De	24a. Was an autopsy performe 1 Yes 2 Eath (Check only one)	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
of V	Physician: this certific ral director,	P	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EP/Out 28a. Date of Injury 28b. T	and the second s	Home 5 Residence	e 6 Other (Specify)
Division	or Attending I after death. Diractor: After in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) Ir 28e. Place of Injury - At home, far	njury Work? M 1 □ Yes 2 □ No	28I. Location (Stree	et and Number or Rural Route Number,
ā	To tha Hospital or Atte within 24 hours after de To tha Funaral Diracte completely filled in by th	edical Cert	29a. Certifier 1 Certifying Phy	building, etc. (Specify) sician: To the best of my knowledge. ner: On the basis of examination and	death occurred at the time, date and place	City or Town, Some	se(s) and manner as stated.
	To tha h within 24 To tha F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)

State Registrar

			1 - For State Registrar	State o	f Marylar	nd / Dep <i>Ce</i>	artment ortificate	of Hea	lth and N ath	lental Hy	/giene Reg. No.	200	13229
			Decedent's Name (First, Mide	fle, Last)						2. Date of D	eath		3. Time of Death
	Physici /Medio		LOEY ELIZABET	H BRANT CO	PPAGE					MARCH	30, Day	2004 Year	7:55 A M
	Examir		4a. Facility Name (If not instituti						ation of Death		4c. (County of Dea	
			SOUTHERN MARY 5. Social Security Number	LAND HOSPI	TAL 7. Age (In yrs.	last hirthday		LINTO	Inder 24 Hrs.	R Data of Bi		RINCE G	
	Funeral Director		552-20-9611	1 ☐ M 2 🔀 F	,	1 Yrs.			ours Min.	8. Date of Bi (Month, D JUNE 1	ay, Year)	1 C	thplace (State or Foreign ountry) K
	pu ,		Usual Residence of Decedent		10.0	-							1
	arylar show	5	MD PRIN	y CE GEORGES		ty, Town or L PPER MA	ocation ARLBORO)					10d. Inside City Limits 1 ☐ Yes 2 🕍 No
	the N 28a-f	rect	10e. Street and Number	OL GLORGE		T DIC TH	10f. Zip Co				10a. Citiz	en of What C	
,	ath with the Marylan 23a or 28a-f show ust be rollified at	ai Di	9620 GREEN AP	PLE TURN				772				USA	•
Cul	ler death w Items 23a	ner	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U	I.S. 13.	Was Deceder If Yes, specify	nt of Hispan	ic Origin? (Sp	ecify Yes or N	0- 1	4. Race - Ame Black, Whi	
36	ilide within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or ttems 23a or 28a-f show off, the Medical Examination institution at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	rried 1 ☐ Yes If Yes, Gi	2∭No ve		1 ☐ Yes 2 📆		ecify:	, , , , , , , , , , , , , , , , , , , ,		Specify: WF	
55	tural Ex	edb		d Year or E	7a (85)	16a. Dece	dent's Usual (Occupation			16b. Kin	d of Business	/Industry
7. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	hin 72 9. an "ne Medi	piet	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4or 5+)	(Give	kind of work of DO NOT use	done during retired)	most of work	ring			,
7 2	ygien ygien t,	Con	12			ENT	TREPREN					rail	
2	be fill be fill be of orth	Be	17. Father's Name (First, Middle LOUIS JOSEPH					18.		e (First, Middle JOHNSON		Sumame)	
	should and Me mark matic	2	19a. Informant's Name/Relation			19b. Maili	ina Address (S	Street and N		al Route Numb		Town State	Zin Code)
7 2	alth ar 27 Is		GLENDA SUE CO		DAUGHTI		_			ANNAPOI			
7 9	of Her of Her Fitem		20a. Method of Disposition 1 □ Burial 2 🌣 Cremation	2 Domewal from		Place of Dispo cemetery, cre	osition (Name matory or othe	of er place)		Date	20c. Loc	ation - City or	Town, State
36	Page ment ant: It		*4 □ Donation 5 □ Other		HUI	NTT CR	EMATORY	Z	4/3/	2004	WALI	DORF, 1	ID .
3-30-4 Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after dea popartment of Haalth and Mantal Hygiene. Important: If item 27 Is marked other transmit or other traumatic event. It is Medical Example once.		21. Signature of Funeral Service	Licensee			2. Name and $ ho$, KO	BERT E	. EVAI	NS FUNI MD 20	ERAL HOME 0715
1.1			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that of	caused the deat	th. Do not en	ter the mode o	of dying, su	ch as cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a		BRI	16	ANG	XIA				Onset and Death
	/Medical Examiner		Tooling in dozan,	Due to	(or as a consec		4		DEM	A			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	(or as a conseq	uence of):	RY		DEM	4			
	ecuted ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last)									
8760	cate be executed obysician and the burial-transit	ai Ey	resulting in abatily East	Due to	(or as a consec	juence of):							
687	phy the	edicai		d									
	h certi ending	M/UE	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		⊒Ectopic preg	nancy			23	3d. Date of de	·
P O Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown		nant at time of c		Other (speci					Month	Day Year
	that the set by a detack	Phy	Part II. Other significant condit	ions contributing to d	eath but not res	ulting in the u	ınderiving caus	se given in	Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
LOEYE	uires n sign	d by						,		1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
200	law requires as been sign 2 should be	Completed								24a. Was		24b. Were au	itopsy findings available
90	ician: The lav certificate has ector, page 2	mo:								auto perfe 1 ☐ Yes	ormed?	death?	completion of cause of
1 i	Physician: rthis certifica	Be	25. Was case referred to medic examiner?						Place of Deatl	h (Check only	one)		
0) 5	Physi this o	To	1 ☐ Yes 2 € No 27. Manner of Death	Hospital: 1 == 28a. Date		ER/Outpatier				me 5 ☐ Resi 28d. Describe			city)
200	fing After fune	tion	1 Natural 5 Pend		th, Day Year)	Injury	M 280.	Injury at Work? 1 ☐ Yes		280. Describe	now injury	occurred	
Dace	Attending or death.	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At h	ome, farm, st	reet, factory, o	ffice		28f. Location (Street and wn, State)	Number or Ru	ıral Route Number,
0	rs after all Dir	Cert	4 D Normolds	Dulid	ing, etc. (Specia	y) 				Ony or 10	wn, state)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medicai	29a. Certifier 1 Certify (Check only one) 1 Medice	ing Physician: To the I Exeminer: On the b and man	best of my kno asis of examina ner stated.	owledge, deat ition and/or in	th occurred at to evestigation, in	the time, da my opinion	ite and place, i, death occurr	and due to the red at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	To the vithin To the comp	¥.	29b. Signature and title of certif		_			icense num				signed (Monti	
			> Should	fan 1	ND		D	508	862		MAR	CH 3	1,2004
			30. Name and address of perso										
	Sta	te	SHERIF HASS 31. Date filed (Month, Day, Yea	r) 32. F	gistrar's Signa	ature		#103	LANHA	M, MD 2	20706		
	Registi		APR 0	1 2004	الموا	B A	next						

State of Maryland / Department of Health and Mental Hygiene 2000 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** John Joseph Carroll 7:10 Рм 26, 2004 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 14111 Wainwright Court Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1(XM 2□ F 77 Director Oct. 31, 1926 Pennsylvania 206-12-1104 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d, Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 □ No Prince Georges Bowie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14111 Wainwright Court 20715 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 1943-45 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. en *natural', or items Medical Examinar m 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 x No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Broker Of Real Estate Real Estate s 1 and 2 should be filed of the alth and Mental Hygie itam 27 is marked other other traumatic event, IL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carroll Nicholas Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vnt: if itam 27 is vor oft-Judith D. Carroll/ Wife 14111 Wainwright Court, Bowie, Maryland 20715 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Cemetery crematory or other place)
George Washington
Cemetery 3/31/2004 Adelphi, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury o Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Prostate Cancer One Year /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a concecuarios of) Examiner physician and s the burial-transit death certificate be executed Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Day Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 2 No been signature bround b 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has s certificate has lirector, page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA ₽ 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) yd ni 4 T Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D34403 3/29/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4175 North Hanson Court, Bowie, Maryland Andrew Dobin, MD 31. Date filed (Month, Day, Year) MAR 2 9 32. Registrar's Signature State 2004

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month noun 24 2004 March 1500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| March 22 Anne Arundel Medica1 Center Anne <u>Arundel</u> 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1 M 2 TF Yrs. 69 1935 Maryland Director 219-34-2653 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or itams 23a or 28a-f show any injury or othar traumatic event, the Medical Exacultar traumatic event, the Medical Exacultar traumatic event, the Medical Exacultar traumatic event, the Medical Exacultar traumatic event, the Medical Exacultar traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? ā 21401 1822 Bowman Drive USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black <u>^</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 6th Homemaker None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Millie Henson Edgar Ewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward S. Calhoun (Husband) 1822 Bowman Dr. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veteran 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cometery 22: Name and Address of Facility 3/30/04 Crownsville, Md. 21. Signature of Funeral Service Licensee Reese & Sons Mortuary, West St. Annapolis, Md. Wm. 821 Lavy B. Beese MOOY83 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) 40 Cancer **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 117Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2/ No Hospital: reatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Injury Natural 2 Accident 5 Pending 1 Tes 2 No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 h To the Fur and manner stated. 29b. Signature an Ititle of certifie 29c. License number 467 DR. Howard on who ampleted cause of death (flem 23a) (Type, Prips) 6 31. Date filed (Month, Day, Year) - MAR 2 32. Reginar's Signaturi State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 004 1- State Registrar #8, per/funeral home, 4/8/0 Certificate of Death WCHD, E.T. Reg. No. Amended item 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** DEBORAH A. CONNEEN 2004 4 PM 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY MONTGOMERY HOSPICE CASEY HOUSE ROCKVILLE
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F Director 5 1954 MAINE 220-62-8273 Usual Residence of Deceden 4-5-1952 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ast be nutilised at 1X Yes 2 ☐ No Director DELAWARE SUSSEX OCEAN VIEW 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 WILLIAM AVENUE 19970 "natural", or Items 23a US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian traumatic avant, the Medical Examiners Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: WHITE à Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry REAL ESTATE SALES permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Importent: if itam 27 is marked other then any njury or other traumatin Elementary/Secondary (0-12) College (1-4or 5+) 12 REALTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DR. LAWRENCE CONNEEN BARBARA NUGENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORETTA JONES 10499 WEST DRIVE, FAIRFAX, VA. 22030 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State CALVARY CEMETERY 1 X Burial 2 Premation 3 □ Removal from State 4-12-04 SOUTH PORTLAND, ME 4 □Donation 5 (Other (Specify) 21. Sinature of Funeral Service MELSON FUNERAL SERVICES, LTD. WEST AVE, OCEAN VIEW, DE. 1997

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WEST AVE, OCEAN VIEW, DE. 19970 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE RENAL DISEASE 18 MONTHS /Medical Due to (or as a consequence of): Examiner POLYCYSTIC KIDNEY DISEASE SINCE BIRTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lant 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Gout HUPEI 2X No Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2004 D09470 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10400 Connecticut the MD ugene Kensington, mD 31. Date filed (Month Day 32 Registrar's Signature State Side of Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year WILLIAM CLYDE COLLINS APRIL 2004 /Medical 10:02a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corscia Hills Center Centreville Queen Anne's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 217-54-5599 54 Director 13 1949 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mentat Hygiene.
ant: If item 27 is marked other than "natural", or Itams 23e or 28e-f show ury or other treumatic event, the Madical Extraigher is als be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2X No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23770 Handy Point Rd. 21620 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by Specify: White 3 ☐ Widowed 4 🙀 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Home Building Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Claudie Reed Helen Janie Wart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Reed (sister-in-law) 25151 Porters Grove Rd. Worton, MD 20c. Location - City or Town, State 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of I Important: If it eny injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 4/12/04 Kent Cremation Smyrna, DE. 22 Name and Address of Facility
Galena Funeral Home of Stephen L Schaech
118 West Cross St. Galena, MD. 21635 21. Signature of Funeral Service License M00510 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 day Dehydration /Medical Due to (or as a consequence of): Examiner month Capter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 been signed by the attending physician Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes 1 Yes 20,No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 70 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ieral Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of cartified 29c. License number 29d. Date signed (Month, Day, Year) 751735 MO 412604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Delboy, MD 660 Date filed (Month, Day, Year) 32. Regis ar's Signature 6602 Church Hill Rd. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) 1 2 2004 State Registrar DHMH 17 Rev 1/2001

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Physicia /Medic		Don Richard Car							3	19	20	004	6:00 A
Examin	er	4a. Facility Name (If not institution, give			4b. City, To		_				. County o		
		411 Fairview Drive 5. Social Security Number 6. Se		irthday)	Under 1		OWN, I		Date of Bir		ieen .		
uneral irector			M 2□ F 71	Yrs.	Months [Min.	Date of Bir (Month, Da 10/22	7 32	1	Mary.	ace (State or Foi try) Land
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ns 23a or 28a-f shov must be notified at	ai Director	10e. Street and Number 411 Fairview Drive	<u>.</u>		10f. Zip C	ode	21661	216	20	10g. Cit	tizen of Wh	hat Coun	try?
or Iten	by Funerai	11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1∑Xes 2 □ No If Yes, Give Year or Dates:	1	Vas Deceder i Yes, specify			n? (Speci Puerto Ri	fy Yes or No can, etc.))-	14. Race Black Specify:	, White, e	etc.
e. sn "natural", Medical Exe	Completed	15. Decedent's Edu (Specify only highest grad	ucation 16a te completed) College (1-4or 5+)	a. Deced (Give I life. D	lent's Usual (kind of work OO NOT use	Occupati done du retired)	ion ring most o	of working		:	ind of Bus	siness/Ind	
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₹ 2 ±		19a. Informant's Name/Relationship (7) Beverly S. Carter			g Address (S airvie					-		162 0	
O = =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	demoval from State	ery, crem	natory or othe	er place)	1	Dai	° 21/04		ocation - C	•	
Department Important: I any injury o		21. Signature of Funeral Service Licens 22. Part 1. Enter the disease, or comp	609	22.	. Name and	Address	of Facility	4,000,000					
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Medical aminer	niner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as a consequence	of):	heat				өзристогу а				Interval betwee
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cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	e Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate case. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence b. Due to (or as a consequence c. Due to (or as a consequence d	o of): o of): h 3 5	Ectopic preg Other (spec	inancy (fy)	in Part I.		23e. Did t	obacco Yes 2 an psy psy 28 No	23d. Date Mont	of deliver	Onset and Death Onset and Deat
is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit of	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate case. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence b. Due to (or as a consequence c. Due to (or as a consequence d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown Intributing to death but not resulting	o of): o of): o of): in the un tutpatient	DEctopic preg Other (spec	(nancy iffy) se given	in Part I.	f Death (23e. Did t 1 24a. Was autor perfo 1 Yes Check only o	obacco (Yes 2 an psy primed? Noone) dence	23d. Date Mont use contrib No 3 24b. We pring de 1 [of deliver	Onset and Death Onset and Deat
fler this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit of	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence b. Due to (or as a consequence c. Due to (or as a consequence d. 23c. If yes, outcome of pregnancy 1	o of): o of): o of): in the un	DEctopic preg Other (spec	inancy ify) se given CC Other:	in Part I.	f Death (ing Home	23a. Did to 1 1 24a. Was autor performed 1 1 Yes Check only of	obacco (Yes 2 an psy primed? Noone) dence	23d. Date Mont use contrib No 3 24b. We pring de 1 [of deliver	Onset and Death Onset and Deat
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	d / Department of Health and I Certificate of Death	Mental Hygier	2004	13235
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	/Medic	cal	JAMES C	DWARD (DOUGLAS 4b. City, Town, or Location of Death	4	4c. County of Death	12:35 AM
	Examin	ier	11308 GREEN	WOOD AVE	PRINCESS AN	NE	SOMER	SET
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. In	ast birthday) If Under 1 Year if Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birtho	place (State or Foreign
	Director		230-52-5669 18 Usual Residence of Decedent	60	113.	4-27-	43	″ V fl.
ırylanc	show	L.	10a. State 10b. County		, Town or Location		1	0d. Inside City Limits 1 ☐ Yes 2 🗙 No
the Ma	or 28e-f show as notified at	ecto	MD. Som€	RSET +	RINCESS HNNE	10n. (Citizen of What Cour	
h with	30 or	Funeral Director	1808 GREENWOOD	AVE	21853		USA	,
ar deat	tems	uner	11. Marital Status	12. Was Decedent Ever in U.s Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Sp. 14 Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
U Z I Z I 3-0000 filed within 72 hours after death with the Maryland	l'o'.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: RL	ACK
72 ho	natur dical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b.	Kind of Business/In	dustry
within	than than he we	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)	TRUCK DRIVER	V	RGU K	OPER
D Della	other other vent, I	Be Co	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	en Surname)	10 0 11
should be	Menta	To	OGRESS W.	Douglas		EE SAVA	GE DOL	IGLAS
and 2 sh	ith and 27 is n treum		19a. Informant's Name/Relationship (Ty)		19b. Mailing Address (Street and Number or Ru 16/2 E.W.1LOW GROVE	HVE LAVE	vor rown, state, 21p	19038
es 1 ar	Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or litems 23e or 28e-f show eny injury or other treumatic event, the Medical Examinating rust be notified at once.		20a. Method of Disposition Burial 2 □ Cremation 3 □ R	20b. Pl	lace of Disposition (Name of emetery, crematory or other place)	-	Location - City or To	own, State
Dailling	tment tent: I jury o		• 4 □ Donation 6 □ Other (Specify)	1AB	ERNACLE CHURCA CEM 4/1	3/04 Ho	RNTOWN	
permit.	Depar Impor eny ir	(21. Signature of Funeral Service License	10	22. Name and Address of Facility B	ENNE	SMITH	17H
			23. Part 1. Enter the disease, or complications, or hear failure. List only on	cations that caused the death	n. Do not enter the mode of dying, such as cardiac		1,1000	Approximate Interval Between
	ysician	g j	Immediate Cause (Final disease or condition resulting in death)	METASTA-	1 1111	YCER		4 Mon THS
	Medical caminer		resulting in death)	Due to (or as a consequ	uence of):			22
		ner	Sequentially list conditions, if any, leading to immediate cause, Enter Underlying	Due to (or as a consequ	uence of):			
Kecute	and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):		-	
ate be e	physician and the burial-transit	dicai E		i.				
ortificat	ing phy e as th	Medi	IF FEMALE:					
DOX eath cer	attend for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic pregnancy		23d. Date of delive Month	ery Day Year
i pe	by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown				
ires tha	signed d be de	l by P	Part II. Other significant conditions con HYPER TER		ulting in the underlying cause given in Part I.		o use contribute to th 2 □ No 3 □ Prob	ne cause of death?
w requires 1	should	ietec	1111012101			24a. Was an	24b. Were auto	psy findings available
The la	ate has page 2	Completed by				autopsy performed? 1 ☐ Yes 2 ☑ 1	death?	mpletion of cause of 2 No
VILAI iclen: 1	sertifica ector, I	Be	25. Was case referred to medical examiner?	lospital:	Othor	th (Check only one)		
Phys	ar this a	. To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 1 28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how in		y)
ending	or: Afte	atio	1 Matural 5 Pending 2 Accident investigation	(Month, Day Tear)	Injury Work? M 1 ☐ Yes 2 ☐ No			
UNIVISION I	after de Directe in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28f. Location (Street a City or Town, Sta		l Route Number,
Hospital	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C			wledge, death occurred at the time, date and place tion and/or investigation, in my opinion, death occu			
To the	within 3	Med	29b. Signature and title of certifier	,	29c. License number		Date signed (Month,	
			/		240.0			, 2004
					ELM STREET. PRINC	cess An	INE MI	21853
	Sta Registr	ate	31. Date filed (Month, Day, Year) APR 1 3 20	32. Registrar's Signat	ture & sparks			

Please Type or Print in Black Indelible Ink. Ensure All	opies	Are	Legible
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		4	For State Registrar	State of Mary		artment of H			giene () () L	13236
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physici /Medic		WILLIAM HASKE					April	12 2004	12301
	Examin	er	4a. Facility Name (If not institution, give s		10 lan	4b. City, Town, o	or Location of Deat	h *	46. County of Dea	oth of the co
	Funeral		5. Social Security Number 6. Sex	11/1/11/01	yrs. last birthday)	If Under 1 Year			th 9. Bi	rthplace (State or Foreign
	Director		217-30-8648	M 2□F	80 Yrs.	Months Days	Hours Min.	5/24/1	923 Ca.	lifornia
	and w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	to	MD Worcest		erlin					1 No 2 □ No
	n the	Director	10e. Street and Number		.,	10f. Zip Code			10g. Citizen of What C	country?
	within 72 hours after death with the Maryland one. Than "natural", or Itams 23a or 28a-f show Ita Modical Examiner mant be notified at	ralD	9715 Healthwa	y Drive		21811			USA	
	er dez Itams	Funeral		12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Was Decedent of h f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - Am Black, Wh	
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:	46	1□ Yes 2 No	Specify:		Specify: Wh	nite
21215-0036	72 hou	Completed by	15. Decedent's Edu (Specify only highest grade		16a. Deced	tent's Usual Occup	pation during most of wo	rkina	16b. Kind of Business	s/Industry
2	ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	try Far	d)	9	Agri quil t	-11.00
C	filed Hygi thar int.		17. Father's Name (First, Middle, Last)		Poul	cry rai		me (First, Middle,	Agricult	Lure
an	should be filed and Mental Hygis markad othar umatic evant, II	To Be	Edmond DeMar				Elizak	oeth Ma	tthews	
Maryland	E e a		19a. Informant's Name/Relationship (Ty			_			er, City or Town, State,	
	Health Health tem 27 othar tr		Sharon D. Rei 20a. Method of Disposition		hter 37 Ob. Place of Dispo		nol Dr.	, Snow	Hill. MI 20c. Location - City o	
Baltimore,	0 0		1. Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crer	natory or other pla	-		4 Rehobet	
H	Department of mportant: If mportant: If any injury or once.		21. Signature of Funeral Service License		22	. Name and Addre	ess of Facility			•
ñ	Departing Department of the policy of the policy in the policy in the policy in the policy in the policy of the policy in the policy of the policy in the policy of the po	. 1	Muchus DI	oan					l Home, I	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the re cause on each line.	death. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,	Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ASC	-VD					Onset and Death
	/Medical Examiner		1	Due to (or as a co	nsequence of):	the B	Mar an	1	e	
L,	*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):		nee an	Julanie	no-	
	ocuted nd transit	Examiner	that initiated events	Herere	periph	eral jo	ascular	disa	se	
60,	The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a co	rtsequence (et):					
09289	physi s the b	edical		l						
Box (death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pa		Tetasia araanaa	.,		23d. Date of de	elivery
	e death he atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time 9 Unknown		Ectopic pregnanc Other (specify)	у		Month	Day Year
P.0	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions cor	stributing to death but no	ot resulting in the u	nderhing cause gi	ven in Part I	23a Did t	obacco use contribute t	to the cause of death?
Records,	uires tha signed Id be de	d by	CVA	outing to doubt but no	t resulting in the di	ndonyang dadao gn	on an raiti.			robably 4 Unknown
50	w requ	olete	Destatos					24a. Was		utopsy findings available
Re	The lav	Completed						autor perfo	rmed? death?	completion of cause of s 2 No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					ath (Check only o	one)	
of Vital	S D	2	1 ☐ Yes 2 No	lospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien	1 3 DOA		1	dence 6 Other (Spenow injury occurred	ecify)
	ding f th. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	Wo	rk? Yes 2 No	200. 196301196 1	low injury occurred	
Division	I or Attandi after death. Diractor: A I in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number or R	iural Route Number,
	ital or irs afte ral Dir led in			bullarity, oto. (c						
	To the Hospital or Attanding Ph within 24 hours atter death. To the Funeral Diractor: After th completely filled in by the funeral	Medical		sicien: To the best of manner: On the basis of exa and manner stated.						
	o the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
	> = 0		V Change	to no		BD	155413	7	4/12/0	4
C	; 1			impleted cause of death	(Item 23a) (Type,	Print)				101
		ate-	NICHO (45 J)	32. Registrar's	Signature	texell s	T 5.42	LISBUIY	mp 21	501
	Sta Registi		31. Date filed (Month, Day, Year) APR 13 20	32. Registrar's	H. A	seede				

		Please	e Type or	Print	in Blac	k In	delibl	a Ink	Fnei	ıra A	II Conie	eΛ	re I ea	ible		
	For	1 10000									lental H		ne - a		100	07
	1 - State Registrar					Ce	rtificat	e of	Death			Reg		104	132	31
	Decedent's Nam	e (First, Middle, L	ast)								2. Date of I	Death	D	· · · · ·	3. Time of De	
an :al	MARY LOU	ISE DADD	S								Month APRIL		Day 2	Year 004	7:16	\mathbf{P}_{M}
er	4a. Facility Name (lf not institution, gi	ive street and nu	ımber)			4b. City,	Town, o	r Location	of Death			4c. County of Deeth			
	CORSICA 1	HILLS NU	RSING HO	ME			CENTI	REVI	LE				QUEEN ANNE'S			
	5. Social Security N		Sex	7. Age (I	n yrs. last bi	rthday)	If Under		If Under Hours	24 Hrs. Min.	8. Date of E	Birth	ear)	9. Birth	plece (State or F	oreign
	213-24-1	168	1□ M 2□ F		93	Yrs.	Months Days Hours Min. (Month, Dey, Year MAR. 17, 19									
	Usual Residence of				On City Tow	1										
_	10a. State	10b. County		10	0c. City, Tow	m or Lo	ocation								10d. Inside City L	
ş	MD	QUEEN A	ANNE'S		CENTRE	:VII	LE								1 🗌 Yes 2	X No
Olre	10e. Street and Nur						10f. Zip Code					10g	l0g. Citizen of What Country?			
la	104 TILGI	IMAN AVEI	NUE #211				21617 USA						A			
ne	11. Marital Status		12. Was Dec Armed F	edent Eve	er in U.S.	13.	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							ce - Americ	can Indian,	
Ę		ied 2 Married	1 ☐ Yes If Yes, G	2 No			1 ☐ Yes 2 ☐ XNo Specify:						Specify:			
q p	3X Widowed		Year or [Dates:										WH	ITE	
lete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done life. DO NOT use retire								durina mos	st of work	ing	16	b. Kind of B	usiness/In	dustry	
Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME															
ပိ	17 Fatharia Nama	(Fine Middle Lee			HO	MEM	AKER		40 14-4		(F) . A 41 . I					
Be	17. Father's Name (First, Middle, Last) BENJAMIN FRANKLIN HESSEY 18. Mother's Name (First, Middle, Maiden Sumame) ANNIE FITHIAN											ne)				
٦	THE TIME															
0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE MOCK / GRANDDAUGHTER 708 CHURCH HILL ROAD CENTREVILLE MD 21617															
												1617				
	1 X Burial 2 Cremation 3 Removal from State						rematory or other place)									
	*4 Donation 5 Other (Specify) CHESTERFIELD CEMETERY 4/22/04 CENTREVIL										/ILLE	, MD				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HO											I. HOME.I	P. A.			
1	thor	now L. A	Elferla	n		4	$08 \ S0$	UTH	LIBER	RTY S	TREET.	CI	ENTREX	ILLE	. MD	
	23a. Part1. Enter the shock, or hea	he disease, or cor int failure. List only	noications that	caused the	e death. Do	not ent	ter the mod	e of dyin	g, such as	cardiac d	or respiratory	arrest			Approximate Interval Between	en .
	Immediate Cause disease or condition	(Final	100	id	ntaa	D	1		tha	2					Onset and Dea	th
	resulting in death)	-	a. Due to	(or as a co	onsequ no	of):	1100	110	C//C						gear	
			_		U									-		
Jer	Sequentially list con if any, leading to in cause. Enter Union	nmediate 🜃	Due to	(or as a co	onsequence	of):										
mlne	Cause (Disease or that initiated events	injury	C													
Exa	resulting in death) I		Due to	(or as a co	onsequence	of):										
cal			d.													
ed	i.															
F FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Da									te of delive	erv						
icla	in the past 12	months?	4☐Pregi	nant at time]Fetal death e of death]Ectopic pr] Other (sp							nth	Day Year	
hysi	9 Unknown		9□ Unkn	own												
d by Physiclan/Medical Exa	Part II. Other signif	icant conditions	contributing to d	eath but n	ot resulting i	n the u	nderlying c	ause give	n in Part I		23e. Did	tobac	co use cont	ribute to th	e cause of death	1?
QP	amal phillation									3 □ Prob	ably 4 □Unkr	own				

Pnysician /Medical Examiner

Physici /Media Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show eny injury or other traumatic event, the Modest Examiling American and injury or other traumatic event, the Modest Examiling American

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and

Complete 25. Was case referred to medical examiner? Be ၉ 27. Manner of Death Certification:

Medical

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria death. within 24 hours after

Division of Vital Records, P.O. Box 68760,

2 State

Registrar DHMH 17 Rev 1/2001

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number D47627

3□ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes ②No

24a. Was an autopsy performe

1 Yes

Cther: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

21617

26. Place of Death (Check only one)

CENTREVILLE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

KATHLEEN HOEY, MD 2540 CENTREVILLE ROAD,

31. Date filed (Month, Day Year)

1 ☐ Yes 2 No

2 Accident

3 🗀 Suicide

4 Homicide

32. Registra Signature

ORIGINAL

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

		For State Registrar	State of	Maryland /	Depa Ce	artment	of H	ealth Death	and M		giene Nog. No.	200	4	13239
		Decedent's Name (First, Middle,								2. Date of Dea			ear	3. Time of Death
Physic /Medi		Elizabeth Stell	a FUNK							March			oa!	10:45 p. [™]
Exami		4a. Facility Name (If not institution, g		ber)		,		Location				County of		
	41	968 Mt. Holly D						polis				nne A		
Funeral		5. Social Security Number 6 199–38–5998	3. Sex 7 1 ☐ M 2 💢 F	'. Age (In yrs. last. 54	birthday) Yrs.	tf Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Sept. 4	Year)	40 P	Count	ace (State or Foreign ry) sylvania
Director		Usual Residence of Decedent		74						sept.	+,17	49 1	CIIII	3y I Valifu
yland yland		10a. State 10b. County		10c. City, To	own or Lo	cation							10	d. Inside City Limits
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or 28	Oire	10e. Street and Number				10f. Zip		04101			10g. Citi:	zen of Wha		ry?
within 72 hours after death with the Maryland ene. then "naturel", or Itema 23a or 28a-f show ta Medical Exactirer must be rodified at	Funeral Director	968 Mt. Holly						2140				US		
er de Item	nue	11. Marital Status 1 ☐ Never Married 2 🕅 Married	Armed Ford		13.	Was Deced If Yes, spec	ent of Hi rly Cubai	spanic Or n, Mexica	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		I4. Race - Black, 1	Amenca White, e	
It, or	by F	3 Widowed 4 Divorced	If Yes, Give	•		1 ☐ Yes 2	No 🕅	Specify:	:			Specify:	wh	ite
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thin 7.	ple	(Specify only highest Elementary/Secondary (0-12)	Grade completed) Coltege (1-	4or 5+)		kind of wor DO NOT us		luring mos)	it of work	ng				7 1
ed wil	Completed	12	0		bo	okkee	per						tary	club
d oth	Be	17. Father's Name (First, Middle, La Sid Urbansky	ist)							(First, Middle, Price	Maiden	Sumame)		
ould Men narke	L _O		- CT		01-11-11		(0)				- 01	T		
d 2 st th and 7 Is n traun	i l'	19a. Informant's Name/Relationship John C. Funk —				-				al Route Number apolis,				•
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event. The Medical Examinational bancelined at once.		1 X Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe				natory`or of 1 Ceme			3/18	704	Ная	gerst	own,	Maryland
artme corter injur		21. Signature of Funeral Service Lie				2. Name and		t_	ity M	INNICH	FUNE	ERAL I	HOME	
Departi Depart Import any ir		Scott Min	niels			415 E	. Wi	lson	Blvd	., Hage	rsto	wn, l	id.	21740
n e W		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that can	used the death. D	o not ent	er the mode	of dying	g, such as	cardiac	or respiratory arr	est,			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		Latina	(anc	2							Onset and Death
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Examiner	L.	Sequentially list conditions, b. Due to (or as a consequence of):												
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death certificat e attending phy id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy								23d. Date of delivery				у
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	o Be	25. Was case referred to medical examiner?	Hospital:				Othe	.5.		(Check only or				
<u>a</u> = <u>a</u>		1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of	patient 2□ER/ finjury 28t	outpatier o. Time o		Bc. Injury Work	4 NI	ursing Ho	me 5 Residence 128d. Describe he			Specify)	
ding th: : Afte	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		, Day Year)	Injury	М		:? ∕es 2 🗌	No					
Atter	ifica	3 Suicide 6 Could no	ad 286. Place o	of Injury - At home, g, etc. (Specify)	farm, str	eet, factory	office			28f. Location (Si City or Town			r Rural	Route Number,
tal or s afte el Dir ed in	Certification:	4 LI HOMIGIGO	Odildilli	g, etc. (Specify)						Only of Your	i, Giale)			
To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edicai	(Check only 2 Medical E)	Physician: To the base	sis of examination	dge, deatl and/or in	h occurred a	it the tim	e, date ar inion, dea	nd place, a	and due to the c ed at the time, d	ause(s) ate and	and manne	r as sta	ited. the cause(s)
thin 2 the 1 mplet	Med	29b. Signature and twee of certifier	and manne	er stated.			License					signed (A		
5 1 × 5		250. Signature and the or certifier				<	2000	120	of.	/	110	- Í	10	1.016
10		30. Name and address of person wi	ho completed cause	of death (Item 22)	a) (Type	Print)		1150	1	1	VLAN	CU	1>	0004
5		P. AV BERSON W	MAT AAN	4 NN	Bear	and	<7	ne 3	00	Anna	olis	N	0	2140
St	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	V 🔾	June		/		1				
Regist	rar	MAR 16	2004	Men B.	B	retel								
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? () [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2131 PM Marc Gearldine Patricia Freeman 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2₩F Director 56 Jan. 28, 1948 195-36-7481 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner count be notified at 1 ☐ Yes 2 ☑ No Director Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a 11403 Stonecroft Ct., Apt. 110 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or the any njury or other traumatic event, the Medical Examena 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant <u>Manager</u> 12 th Apartment Leasing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oliver Rodgers Clark Mary Ellen Colbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 N.Main St., Apt 414 Chambersburg, PA 17201 Mary E. Hunter / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ⁴ □ Donation 5 □ Other (Specify) Corpus Christi Cem. 3/15/04 Chambersburg, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gerald N. Minnich Funeral Home 305 N. Potomac St. Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL HOUTE 30 MINUTES /Medical Due to (or as a consequence of). Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ITUS PHENMONIA SETZURE 24a. Was an autopsy performed2 FARUNT CARSICMYOPATHY 25. Was case referred to medical examiner? MORGID ORES ITY HYPERLIA DE 714 26. Place of Death (Check only one) Be 1 / Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Alter 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SuitE

32. gegistrar's Signature

			1 = For State Unpend Item	State of M 23a, Part II,27	laryland ,28a-f,	/ Depa Per Me	artment of h	lealth a Sea th	and Mental	Hygien	2004	132	41	
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	n the	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C	Country?		
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920	172 hours after death with the Marylan "natural", or Items 23a or 28e-f show often Examiner man be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Mari 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	? No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin, Mexican Specify:	gin? (Specify Yes o , Puerto Rican, etc	or No-	14. Race - Arr Black, Wh Specify:			
Maryland 21215-0036	ithir Ben Ben	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or		16a. Dece	dent's Usual Occupi kind of work done of DO NOT use retired	during most	of working		Kind of Busines	Ĺ		
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E C	Pages nent of int: If it iry or o		1 Burial 2 Cremation 1 Onnation 5 Other (S		•		natory`or other plac VETERANS	,	4/22/04	MI	LLSBORO	, DELAW	ARE	
Baltimore,	permit. Page Department of Important: If any injury or 2005e.		21. Sign sure of in uneral Service	Hart			2. Name and Addres		•					
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.O. Box	that the death certificate led by the attending phys detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal d	leath 3 [Ectopic pregnancy Other (specify)			_	23d. Date of de Month	,	Year	
٩.	The law requires that tte has been signed b page 2 should be deta	by	Part II. Other significant condition Atherosclerotic				nderlying cause give	en in Part I.			.)	to the cause of d		
Vital Records,		Completed							— L	Was an autopsy performed? 'es 2 ☐ No	prior to death?	utopsy findings completion of c s 2□ No	available ause of	
<u> </u>	siclan certif rector	o Be	25. Was case referred to medica examiner? 1 ⚠ Yes 2 ☐ No	Hospital-	. X	R/Outpatier	t 3 DOA Othe	250	of Death (Check of	-				
ō		H-	27. Manner of Death	1 ☐ Inpati	ury 2	8b. Time o	28c. Injury	at at	rsing Home 5 🗌 28d. Desc	ribe how inju		ecity)		
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Division	al or Attandir after death. I Diractor: Af d in by the fu	Certification:	3 Suicide 6 Could 4 Homicide determ	not be ined 28e. Place of In	ijury - At hom	e, farm, str	eet, factory, office		28f. Locati City o	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	To the Hospital within 24 hours a To the Funeral C completely filled	Med	29b. Signature and title of certifie		29c. License number O.C.M.E.						29d. Date signed (Month, Day, Year) April 19, 2004			
			30. Name and address of person	who completes cause of	death (Item 2		Print) 111 Penn	Stree	t. Raltin	nore 1	Marvi an	d 21201		
	Sta Registr	a	31. Date filed (Month, Day, Year)	3 2004 32. Regis	far's Signatu	re /	Spor		-, mill		y	~ ~12UI		

		•	1 - State of Ma	ryland /	Depar Cert	tment of F ificate of	lealth and N Death	Mental Hy	giene2	004	13242				
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death				
	Physicia		Lavon Elizabeth Grim					April	08. 20	004	11:30 aM				
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)			4b. City, Town, o	or Location of Death	: Uhili		nty of Death) 11.50 dii				
	LAGIIIII	-	Reeder's Memorial Home			Воо	nsboro			Washi	ngton				
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AVON 215-0036	72 hours after natural', or Ite	þ	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		11	∐Yes 2⊠ No	Specify:		Spe	ocify: Wh	ite				
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aryland	2 should be filed within 72 hours and Mental Hygiene. Is merked other than "natural", aumatic event, I'm Medical Exa	Be						Savilla							
그를	hould d Mer mark matic	ပု	Philip Noah Jamison 19a. Informant's Name/Relationship (Type, Print)	19	9b. Mailing	Address (Street	Agnes and Number or Rui				(Code)				
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	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Merial Hygiene. The state of the st		20a. Method of Disposition	20b. Place	of Disposi	tion (Name of atory or other pla		Date		on - City or To					
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O B	Departimbo Impo any Ir		21. Signature of Funeral Service (Cersee) 22. Name and Address of Facility Home, P.A. 21795 425 S. Conococheague St. Williamsport, Maryland Approximate Interval Between shock, or heart failure. List only one cause on each line.												
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م َ	that the	Y P	Part II. Other significant conditions contributing to death but	ıt not resulting	g in the und	lerlying cause gr	ven in Part I.	23e. Did	tobacco use c	ontribute to th	he cause of death?				
rds	w requires to been signer should be considered.		Cucihom sum	0	amis	I.		1 🗆	Yes 2 □ No	o 3 🗆 Prob	pably 4 Dunknown				
Ö	s bee	ete						24a. Was		b. Were auto	psy findings available impletion of cause of				
Be	The lay ate has page 2	Completed						auto perf	ormed?	death?	·				
ta	ician: T certificat ector, p	0	25. Was case referred to medical				26. Place of Dea								
<u> </u>	ysician; is certific director,	ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatier	nt 2 🗆 ER/0	Outpatient	3□ DOA Ot	her: 4 Aursing H	ome 5 🗀 Res	idence 6 🗀	Other (Specif	y)				
Division of Vital Records,	Hospital or Attanding Physician: The law requires that the death certify hours after death. 24 hours after death. Funeral Director: After this certificate has been signed by the attending teller filled in by the funeral director, page 2 should be delached for use as telly filled in by the funeral director, page 2.		27. Manner of Death 28a. Date of Injur 1 ☐Natural 5 ☐ Pending (Month, Day	y Year) 28b	. Time of Injury	28c. Inju Wo		28d. Describe	how injury oc	curred					
Ö	andir sath. or: Af he fu	Satic	2 Accident investigation			M 1	Yes 2 No								
Ξ	st or Attandir after death. I Director: At d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Inju building, etc	ıry - At home, c. <i>(Specify)</i>	farm, stree	et, factory, office			(Street and Ni wn, State)	imber or Rura	al Route Number,				
	spital or ours afte neral Dir filled in I			- f 1 1	la a da ath		in a data and place	and due to the		I manager as a	tatad				
	e Hospital 24 hours e Funeral letely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of 2 Medicel Exeminer: On the basts of and manner sta	examination:	and/or inve	stigation, in my	opinion, death occu	rred at the time	, date and place	ce, and due to	the cause(s)				
	To the Hosp within 24 ho To the Fund completely f	Med	29b. Signature and title of certifier			29c. Licen	se number		29d. Date sig	gned (Month,	Dey, Year)				
			- ONE MO			D (5	8019		APRIL	9,20	104				
	d		30. Name and address of person who completed cause of de	eath (Item 23a	a) (Type, P	rint)				•					
こうも	t d		Dr. Vasant Datta 340 Mill	St.,	Hager	stown, I	MD 21740	/ 301	- 739 - 7	100					
	Sta	ate	31. Date filed (Month Day) Year) 2 2004 32. Registra	ar's Signature	A	- 11:									
	Regist	rar	- ~ 2007	10.	Poplar	e ser									

State of Maryland / Department of Health and Mental Hygiene 001

13243

						Certifica	te of	Death		Reg. No.	U4	13243
g	Dhuaia	(P)	1. Decedent's Name (First, Middle, Las	it)					2. Date of D	eath Day	Year	3. Time of Death
	Physic /Medi		Charles Victor	Goldin	g				3 ,		04	16.30
	Exami		4a. Facility Name (If not institution, give	street and number)	J			4b. City, Town, or	Location of Dea	th 4c. County	of Deeth	
		77	₁₄ 133 Zinnia Lane					Hagerst	agerstown Wash			1
	Funeral		5. Social Security Number 6. So	ex 7.Ag □M 2□F	e (In yrs. last bir	Yrs. If Und	or 1 Year Days	If Under 24 Hrs Hours Min	Under 24 Hrs. 8. Date of Birth			ace (State or Foreign ry)
α^{ϵ}	Director		118-24-6144 X Usual Residence of Decedent						Mar.6,	1932	N.Y.	
	and		10a. State 10b. County		10c. City, Town	or Location					10	d. Inside City Limits
	Mary f she	6	Md. Washingto	n	Наод	erstown						1 ☐ Yes 2 ☐ No
	the 1	Director	10e. Street and Number		1,446		ip Code			10g. Citizen of	What Counti	21
C	with sa or	0	14113 Zinnia La								What Count	y.
-	daath ms 2;	by Funeral	14113 ZIIIIII La La	12. Was Decedent I	Ever in U,S.		1.740 edent of F	lispanic Origin? (Specify Yes or N	USA 14. Rac	ce - Americai	n Indian.
20	r ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Tyyes 2 □ N	No	If Yes, sp	ecify Cuba	an, Mexican, Puèi	to Rican, etc.)	Bla	ck, White, et	tc.
3020 inc	hours aftar daath with the Maryland turel', or items 23a or 28a-f show al Examiner mast be notified at	2	3 ∰Widowed 4 ☐ Divorced	If Yes, Give 1	950–53	1 ☐ Yes	XXNo	Specify:		Specif	White	<u>.</u>
7. C. J.	72 hc	Completed	15. Decedent's Ed		16a.	Decedent's Us	ual Occup	pation	edein a	16b. Kind of B		
27	an e	ם	(Specify only highest grad	College (1-4or 5	+)	life. DO NOT	use retired	during most of wo d)	rking			
	od w rgien ar th	ပ္ပ	12			Clerk	C			Retail		
1 Pu	tal H d oth	Be	17. Father's Name (First, Middle, Last)							, Maiden Surnan		
o Z	Men Men arke	ပို	Ralph B	Goldin				Doroth			Anthon	-
Re Ces Maryland	2 sh and is m		19a. Informant's Name/Relationship (7					and Number or R				lode)
	l end lealth m 27	1 5	Hazel E. Fields /E	xecutrix				ive. Maug				
Baltimore,	permit. Pages 1 end 2 should ba filed within 72 hours aftar daath with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked othar than "neturel; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mast be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			Disposition (Na y, crematory or			Date	20c. Location -		
# 1	t. Pa Itmer Itant: Ijury		4 ☐ Donation 5 ☐ Other (Specify		Hagers	stown Ci			4/9/04	Hagersto	own, M	d.
Bal	permi Depar impor any ir		21. Signature of Funeral Service Licens	800		22. Name a	nd Addre	ss of Facility Bu	ırner Tr	ade Serv	rices	P.A.
	10 v		Rb read 6	Buns	el!	1037 Du	ıal F	Pl. Hager	stown,M	d. 21740)	
			23a. Part1. Enter the disease, or comp shock, or heert failure. List only of	lications that caused ne cause on each lin	the death. Do n	ot enter the mo	de of dyir	ng, such as cardia	c or respiratory a	rrest,	P	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final		1 1	0.7	4	1 4				Onset and Death
	Examiner		disease or condition resulting in death)	. Meta	static	136	dol	er Co	rane	ma	1 (Jean
		e			Due to (or as a c	onsequence of	:					,
	uted ansit	edical Examiner		b								
Ć,	eath certificete ba executed ettending physicien end ifor use as the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a c	onsequence or,						
92	te ba ysicie	Cal	triat initiated events	cr	Due to (or as a co	onsequence of)		70.00				
x 68760,	tifice as th	Pa	resulting in death) Last				•					
	th cer endir r use	an/M		d								-
Э. Е	Attending Physicien: The law requiras thet tha death r death. r death. ector: Atter this cartificata has been signed by the etter by the funerel diractor, page 2 should be datached for u	Physician	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	the underlying	cause giv	en in Part I.	23b. Did	tobacco use cor	ntribute to t	he cause of death?
P. O.	et tha I by th atach	풀							1 🗆	Yes 2 No	3 Proba	bly 4 🗆 Unknown
<u>v</u>	as th igned	۵	A 90									
50	v requira been si should l	ğ							24a. Was perfo	an autopsy	availa	e autopsy findings able prior to
ခိုင	elawı hasbı ge2st	출			71.						of de	pletion of cause eath?
=	The sata h	Completed							10	Yes 2 140	101	Yes 2□ No
/its	nysicien: The la nis cartificata has I diractor, page 2	Be	25. Was case referred to medical examiner?	1					ath (Check only o	nne)		
of	hysi this c	2	IL 165 Z DAVO	lospital: 1 Inpatier			_	4LI Nursing F		dence 6 □Othe		
E C	ding F h. After funer	0	27. Manner of Deeth 1 ☑ Maturel 5 ☐ Pending	28a. Date of Injun (Month, Day	y 28b. Ti ' <i>Ye</i> a <i>r</i>) In	jury	28c. Injury Worl		28d. Describe	now injury occurr	ed	
isi	death death ctor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	OO - Disease (India	- 411	М		Yes 2□No	006 1			
Division of Vital Records, P.O. Bo	or A aftar Direc	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At nome, fan . <i>(Specify)</i>	m, street, tactor	у, опісе		City or To	Street and Numb vn, State)	ar or Hurai H	foute Number,
	pours ours perai filled	0	29a. Certifier 1 Certifying Phys	sician: To the best of	f my knowledge	death occurred	at the tim	o date and place	and due to the	onuco/s) and ma		-
	24 h	edical	(Check only 2 Medical Exami	ner: On the basis of	examination and	or investigation	in my or	pinion, death occu	rred at the time,	date and place, a	and due to th	ne cause(s)
	To the Hospital or Attendition within 24 hours aftar death. To the Funeral Director: A completely filled in by the funeral by	Me	29b. Signature and title of certifier			29	c. License	e number		29d. Date signed	i (Month, Da	ay, Year)
				Way.	0		1)2	-1457		4-7	-200	4
	44	}	30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (T	ype, Print)		,		- 1 - 1		
2			ABOUL WATE	EA U1)_	1282	1-0A	-H	IC AVE	. HAG	ERSTOR	Vr. il	4021742
	Sta	_	31. Date filed (Month Day Year)	004 32. Registra	r's Signature	1						•
	Registr	ar	d. 14 4	THE WALL	w st.	Oparki	1					

State of Maryland / Department of Health and Mental Hygien [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Vear Sharon Ann Gay 2145 /Medical 2004 4a. Facility Name (If not institution, give street and number) Examiner nber)

Spital Hagerstown

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Year)

Months Days Hours Min. Feb. 12, 1960 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√XF Mary land 212-82-0769 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~~** any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XXNo Washington Maryland Sharpsburg 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 5024 Harpers Ferry Road 21782 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Health & Human Aide Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard Alvin Phyllis Caroline Livengood ္ရ Keating 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Scott Gay - Husband 5024 Harpers Ferry Road Sharpsburg, Maryland 21782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery Apr.8,2004 Sharpsburg, Mary Land 21. Signal re of Fineral Servi OSDEPARE AFROME FEITH HOME, P.A. 425 S. Conococheague St.Williamsport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Melzstabe disease or condition resulting in death) Breast 6 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner physician and the burial-transit Hospital or Attanding Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ίο Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1⊟ Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Date signed (Month, Day, Year) 041667 Michael of Mularganh 5H-U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Campos Bestown McCormack 11110 2004 32. Registrar's Signature. 31. Date filed (Month, that (Year)

DHMH 17 Rev 1/2001

State

Registrar

boardes

S			1 - For State Registrar	State of M	larylan	d / Depa <i>Cei</i>	artment	t of H	ealth a	and Me		giene Reg. No		13	245
			1. Decedent's Name (First, Middle, La	ist)		-					2. Date of De			3. Time	of Death
	Physici /Medi			Greivel							March	6 20	004 Year	740) а ^м
	Examir		4a. Facifity Name (If not institution, gir)				Location o	of Death		4c. County of Death			
			13324 Fairfax Roa	ad.				erst	OWD			V	Vashingt	onCou	ınty
	Funeral		-	Sex 7. A 1020 M 2 □ F		ast birthday)	If Under Months	1 Year Days	If Under Hours	Min.	3. Date of Birt (Month, Da	y, Year)	9. Bir	thplace (Stat	e or Foreign
	Director		217-27-8304 Usual Residence of Decedent	20.111	$M \stackrel{2}{=} F$ 27 Yrs. Worlds O O O O O O O O O O							,19		scons	
	and wo		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits
	Many -t-eh	ğ	Maryland Washing	ton	,	Ingana								1 🗆 Y	es 21 No
	r 28a	Directo	10e. Street and Number	COM	1	<u>lagers</u>	10f. Zip	Code				10g. Cit	tizen of What Co	ountry?	
	13e o	O	13324 Fairfax Ro	ad				21.	742			T7 (C A		
	death	Funeral	11. Marital Status	12. Was Decedent			Was Deced	ent of His	spanic Orio	gin? (Speci	fy Yes or No		S.A. 14. Race - Ame		
စ္	or Ita		Never Married 2 ☐ Married	1 □ Yes 2/CtNo			f Yes, speca 1 □ Yes 2			і, Риело Ні					
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23e or 28a-f show hit, the Medical Examiner must be routified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1 1 1 1 1 2	LAINO	Specify:				Specify: Wh	Lte	
5	72 h natu	Completed	15. Decedent's E (Specify only highest gr		16a. Deced (Give	dent's Usual kind of worl DO NOT use	Occupa k done di	tion uring most	t of working		16b. K	ind of Business	Industry		
72	withir nne. ihan	m du	Elementary/Secondary (0-12)	Colfege (1-4or	5+)										
i D	Hygie ther t		17. Father's Name (First, Middle, Last	1	1	Ele	ectric		19 Motho	ric Nama (First, Middle,		ctrical	Syste	ms Co.
ano	od be) Be									rirst, Middie,	Maiden	Sumame)		
Maryland	should ind Men ind Men ind marke	2	Peter Greive 19a. Informant's Name/Relationship		·	19h Mailin	n Address		Sand		Parkin		or Town, State, a	Tin Codel	
	and 2 salth ar n 27 is		Sandy Prisak/Moth	,, ,									ryland 2		
ē,	s 1 au f Hea ftem othe		20a. Method of Disposition		0.0	ace of Dispos	sition (Nam	e of		Dat			cation - City or		
Ë	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f ehow any injury or other traumatic event, the Macical Examiner must be rutilled at Once.	1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State ☐ Cemetery, crematory or other place)									Had	gerstown	ı. Mar	vland	
Baltimore,	permit. Departir Importa any inju		21. Signature of Fuheral Service Lide	nsee/		22	. Name and	Address			- 1		ery Fune		
m	8 9 1 8 8		Jawler A	Men		13	331 Ea	ster	n Bl	vd. N	. Hage	rsto	own, Mar	vland	21742
- /*			23a. Part 1. Enter the disease, or corr shock, or heart failure. List only	plications that cause one cause on each I	d the death	. Do not ente	er the mode	of dying	, such as	cardiac or r	espiratory ar	rest,		Approxim Interval B	ate
	Physician		Immediate Cause (Final disease or condition	1	t au	nsh	+1	m.	nd	of 1	20-1			Onset an	
	/Medical		resulting in death)	Due to (or as			0) 0		VI ICE	0) ,	1026			-	
4	Examiner	L	Sequentially list conditions,	b											
	De sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):									
_	and and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):									
8760,	ate be executed thysicien and the burial-transit	aiE	· ·			01.00 017.									
687	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner		_ d											
Box	eath certifici attending pl	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of defi	VAD/	
m .	death e atte d for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a			Ectopic pre Other (spe					'	Month	Day	Year
о. О	that the death cer ed by the attendir detached for use	hys	9 Unknown	9□ Unknown											
	w requires that been signed to should be deta	by P	Part II. Other significant conditions of	contributing to death b	out not resul	lting in the un	iderlying cai	use giver	in Part I.		23e. Did to	bacco u	se contribute to	the cause of	death?
ğ	en si									_	1 🗆 Y	es 2[□No 3□Pro	obably 4]Unknown
ecc	ne fawr has be ge 2 sh	Completed									24a. Was a		24b. Were au	opsy finding	s available
<u> </u>		5									perfor	med? 2 🗆 No	death?	ompletion of 2 □ No	Cause of
/ita	ysicien: The is certificate hidrector, page	Be	25. Was case referred to medical examiner?							of Death (C	Check only or				
5	유 부 등	2	1X Yes 2 No	Hospitaf: 1 ☐ Inpatio		R/Outpatient			I 1401.				Other (Spec	ify) at	scene
г С	ding F h. Alter funera	lon	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju	y Year)	28b. Time of Injury	CUM 28			_ i	I. Describe ho	ow injury	occurred	1	II
Sic	Attend death ctor: / y the fi	icat	2 Accident investigation 3 Suicide 6 □ Could not b	20-	9	4.15	AM		s 2 N		July (S	\mathcal{S}^{ϵ}	C4 51	101 24	2()
Division of Vital Records,	i ‡ ‡ c	Certification:	4 ☐ Homicide determined	28e. Place of Inj building, et	c. (Specify)	- (опісе		13	City or Town	State,	Number or Ru	rai Houte Nu	mber,
	spite		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best	of my know	dedge, death	occurred at	the time	date and	Inlace and	dud to the c	(ع)هوريد	and manner as	Co-	
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edicai	(Check only and Medical Example)	niner: On the basis o and manner st	f examination	on and/or invi	estigation, in	n my opir	nion, death	occurred	at the time, d	ate and	place, and due	to the cause	(s)
	To the within To the Comp	×	29b. Signature and title of certifier	\		200	29c.	License r	number		2	9d. Date	e signed (Month	Day, Year)	
			Hot 1 !	lum i		Wel.	us	OC	ME			Marc	ch 7 200)4	
26	1. ~		30. Name and address of person who	completed cause of d	leath ltem	23a) (Type, F	Print)	Dom	, CL.		D-14-		Ma 7	- J 21	201
2)			31. Date filed (Month, Day, Year)	ON CA-	100	XKW	2 +++	rem	ı ətr	eet,	חמדניווו	nre	, Maryla	TIKI ZI	ZU1
	Sta Registr	ie ar	MAR 10 2	004 Lines	ar's Signati	T. Sp	ver								

State of Maryland / Department of Health and Mental Hygiene 2004 13246

						Certi	ificate o	f Death	1		Reg. No.	() "}	101.70	
	Physic /Medi		1. Decedent's Name (First, Middle, Las	SHIRLEY	y G	ROD				2. Date of D Month Aのた;)	eath Day	Year 2 on 4	3. Time of Death 2 3 3 0	
	Exami		4a. Facility Name (If not institution, give Deers Head	street and number)				SAL	15132	cation of Dea	th 4c. Count		120	
	Funeral Director		5. Social Security Number 6. Security Number 11 11 12 13 15 15 15 15 15 15 15 15 15 15 15 15 15	x 7. Ag □M 2[X]F	e (In yrs. last bi		If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of B (Month, D August	irth Pay, Year) 15, 1934		lace (State or Foreign try) yland	
	ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Health end Mental Hygiene. If Item 27 is marked other then "netural", or Nems 23e or 28e-f show or other treumatic event, the M-dical Examera	rector	10a. State 10b. County Maryland Wicomi 10e. Street and Number	.co	10c. City, Tov						10g. Citizen of		0d. Inside City Limits 1X Yes 2 □ No	
	death with	Funeral Director	34675 Main Street 11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Wa	21850 as Decedent of es, specify Cu		igin? (Spe	cify Yes or N	USA	ce - Americ	an Indian,	
0020	hours after ural', or Ite		1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1□]Yes 2⊠N	o Specify:			Specil	Whi	te	
21215-0020	within 72 iene. then net	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or 5)+)		nt's Usual Occ nd of work don NOT use reti ionist	upation e during mos red)	t of workin	ng .	16b. Kind of B		ing Home	
Maryland	should be filed within end Mental Hygiene. s marked other then sumatic event, the Mental Hygiene.	To Be C	17. Father's Name (First, Middle, Last)	aynes		.ccpc			er's Name ildre		e, Maiden Surnar		ing nome	
	1 end 2 sho Health end I em 27 is ma		·	rpe, Print) Isband)	34	1675 1	Main S	reet,		sville	e, Maryla	nd 2	1850	
Baltimore,	t. Pa ntmer ntant:		20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 20c. Location - City or Town cemetery,										y, Marylan	
ä	Deme Depe Impo	0.70	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused	the death. Do							al Ass rylar	Approximate	
J.	Physician /Medical Examiner	ner	shock, or heart failure. List only of Immediate Cause (Finel disease or condition resulting in death)	Carci	ne. noma Due to (or as e	lu	ng				Interval Between Onset and Death			
ox 68760,	The law requires that the death certificete be executed ate has been signed by the attending physician and page? should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	Due to (or as a									
P.O. Bo	that the death c	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to 1 Yee 2 No 3 Projection Projec												
Division of Vital Records,	a law requires th has been signer ye 2 should be d	Completed by									s en autopsy ormed?	ava	re autopsy findings ileble prior to ipletion of cause eeth?	
Vital F	ician: certifica rectol,	o Be Cor	25. Was case referred to medical examiner?	lospital:			-5 0			(Check only			Yes 2LJ No	
sion of	De te od	Certification: To	27. Manner of Death 1 Natural 5 ☐ Pending investigation	28a. Date of Injur (Month, Day	ot 2 □ ER/Ou y Year) 28b. 1	Time of Injury	28c. Inj	4 ALVINU	28		dence 6 Oth			
Divi	pital or Attendir burs efter death. eral Director: Af filled in by the fu		3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Inju building, etc sicien: To the best of	. (Specify)					City or To	(Street and Numb			
	To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b	Medical	(Check only one) 2 Medical Examination (Check only one)	ner: On the besis of and manner stat	examination an ted.	d/or invest	tigation, in my 29c. Licer	opinion, deat	th occurred	d at the time,	29d Date signer	and due to	the ceuse(s)	
			30. Name end address of person who co	Wulauy mpleted cause of de lany M			U	339			april			
Ø	Sta Registr		VIRGINIA A DU 31. Date filed (Month, Day, Year) APR 1 4 20	32. Registra	r's Signature	£ 1.	Sport		2546	113 K	-9 /14	218	02-2018	

Registrar

	AMEND#8 3/31/04 State of Maryland / Department of Health and M 1 - State Registrar AAOO HEALTH DEPT OMH Certificate of Death	lental Hygiene	°2004 13247			
Physician /Medical	1. Decedent's Name (First, Middle, Last) Antonio Griffin	2. Date of Death Month Da MARCH 2	ay, 2004 3. Time of Death			
Examiner Funeral Director	219-72-7024 $MOnths$ Days Hours Min.	DEC 20 2	S. County of Death NNE ARUNDEL 9. Birthplace (State or Foreign Country) Maryland 961			
anyland show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Odenton		10d. Inside City Limits			
death with the Maryland ma 23s or 28s-f show trusts be notified at negal Director	10e. Street and Number 10f. Zip Code	10g. Ci	1 ☐ Yes 2 ☑ No			
	700 Chape1 View Dr. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ XYes 2 □ No If Yes, specify Cuban, Mexican, Puerto Forces? 1 □ XYes 2 □ No If Yes, Sive Year or Dates: 1 □ Yes 2 ☒ No Specify:	ocify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: Black			
21215-0036 ed within 72 hours after Sylene. The Medical Examination, in the Medical Examination of the		Un:	Kind of Business/Industry ited States Val Academy			
laryland 2 2 should be filed and Mental Hygi is marked other aurmatic event, it	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maider				
Maryla Maryla III and Men III	19a. Informant's Name/Relationship (Type, Print) Henrietta Williams (Mother) 19b. Mailing Address (Street and Number or Rural 700 Chapel View Dr.	I Route Number, City or Town, State, Zip Code)				
Baltimore, N permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tr once.		ate 20c. L	ocation - City or Town, State Wnsville, Md.			
Balti Banti Depart Import any inj ance	21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Wm. Reese & Sons 22. Name and Address of Eacility Wm. Reese & Sons 821. West St. Ann	apolis, I	y, P.A. Md. 21401			
Physician /Medical Examiner	Due to (or as a consequence of):	r respiratory arrest,	Approximate Interval Between Onset and Death			
Division of Vital Records, P.O. Box 68760, the Hospitel or Attending Physician: The law requires that the death certificate be executed in the 24 hours after death. The certificate has been signed by the attending physician and repletely filled in by the funeral director; page 2 should be detached for use as the burial-transit Addical Certification; To Be Completed by Physiclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
P.O. Box 6 nat the death certiful d by the attending of letached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of delivery Month Day Year			
rds, P quires tha an signed I uld be det	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TUPE 1 DIAGETED MELUTUS	23e. Did tobacco t	use contribute to the cause of death?			
al Records, The law requires I cate has been signe page 2 should be Completed by	CANDIDA EJOPILAGITIJ	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
Division of Vital Records, P.O. Box To the Hospitel or Attending Physician: The law requires that the death cenwithin £4 hours alter death. After this centificate has been signed by the attending completely filled in by the funeral director; page 2 should be detached for use Medical Certification; To Be Completed by Physiclan/M	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No	(Check only one) ne 5 Residence 8d. Describe how injur				
Division C To the Hospitel or Attending P Within 24 hours after death within 14 hours after death completely filled in by the funers Medical Certification;	4 nomicide building, etc. (Specify)	City or Town, State	,			
the Hosp thin 24 hou the Fune ompletely fill	29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date and	d place, and due to the cause(s)			
To visit vis	29b. Signature and the of 1900 1154409	MAI	te signed (Month, Day, Year) NCH 26, 2004			
	23. Name and address of person who completed gause of death (Item 23a) (Type, Print) ISANIN MALLIEL WORTHARWOOL HOURS HOUSE	MC GU	can Burnice, Marylan			
State Registrar	31. Date filed (Month, Day, Year) MAR 3. 1 2004 32. Resistrar's Signature					

State of Maryland / Department of Health and Mental Hygien [] [] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Horice Year **Physician** 1030AM ELTON ELMORE GRAY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner YENINSULA KLGIONAL MEdical Md Willowill If Under 1 Year | 4 Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Hours 1 M 2□F 217-28-4735 Director 6, 1933 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, it a Madical Examinar must be notified at 1 Yes 2 □ No Director MD Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 South Church St. 21863 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No f Yes, Give 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William E. Gray Lyda Birch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elton E. Gray / 4738 Washington St., Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Whatcoat Cem. 4/14/2004 Snow Hill, MD 22. Name and Address of Facility Holloway Melson FuneralHome, 103 Linden Ave. 21. Signature of Funeral Service Licensee Mille 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
50 Nov Immediate Cause (Final disease or condition resulting in death) Physician uglit cirelial nemis view in /Medical **Examiner** caretal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 1 ☐ You 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a Wasan 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕽 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) a wenner. In. D 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21804 mD RUDNEY A. 1346 S. DIVISION ST. SALISBURY WENRICH, IN. 1) 31. Date filed (Month, Day, Year)
APR 1 3 2004 32. Registrar's Signature State Registrar

For State Registrar Decedent's Name (First, Middle, Last) Month Year **Physician** 1:40 ANNE BARLOW GALLAGHER APRIL 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner OUEEN ANNE'S STEVENSVILLE 503 LOVE POINT ROAD If Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗶 F 38 MARYLAND 214-88-7305 NOV. 8, 1965 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or itams 23a or 28a-f show event, the Wedical Examiner must be notified at 1 Yes 2 No STEVENSVILLE QUEEN ANNE'S MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21666 503 LOVE POINT ROAD Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene important: If Item 27 is markad other than eny injury or other traumatic avant the second injury or other traumatic avant traumatic avant the second injury or other traumatic avant the second injury or other traumatic avant the second injury or other traumatic avant the second injury or other traumatic avant the second injury or other traumatic avant the second injury or other traumatic avant the second injury or other traumatic avant the second injury or other traumatic avant the second injury Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY 12 5+ LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN SCOTT GALLAGHER MARGARET PARR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PETER A. HOLLAND/HUSBAND 503 LOVE POINT RD., STEVENSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 04/03/2004 STEVENSVILLE, MD ` 4 □ Donation 5 □ Other (Specify) 21. Signature of uperal Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastelic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 Who Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 10 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed death? 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Tes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred After t Certification: or Attanding 5 Pending investigation 1 Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To tha Funaral D 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of centrier 04 D1707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Johns Horkins 32. Register's Signature

CHREAK

State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gonman 18STER \mathbf{A}^{M} APRIL 2004 9:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F **Director** 217-44-4022 59 NOV. 16, 1944 PENNSYLVANIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Meulcu Exam as a minut by notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD QUEEN ANNE'S STEVENSVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 JIB WAY 21666 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ENGINEER ENGINEERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT W. GONINAN, SR. EDNA VIXLER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE A. GONINAN/WIFE 104 JIB WAY, STEVENSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or STEVENSVILLE CEMETERY 04/08/2004 STEVENSVILLE, MD 5 Other (Specify) 21. Signature of June Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., STEVENSVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MUDCARDIAL INFARCTION /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 □Unknown 1 TYes 2 No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To ≥ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Death
Natural
Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 1 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 023867 nomos in Walsh. Stevensville, MD THOMAS WALSH, MD 130 Love foint ROAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Spark Registrar APR 0 9 2004

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 14 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death River enT If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Birthplace (State or Foreign Country)

MD 7. Age (In) last birthday) If Under 1 Year ₩ M 2 F 54 220-52-8322 Usual Besidence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 💥 🕶 No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9944 Old Fairlee Road 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Mechanic 17. Father's Name (First, Middle, Last) Edward Gustafson Lula Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Gustafson/wife 9944 Old Fairlee Road, Chestertown, MD 21620 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Chester Cemetery 4-4-2004 Chestertown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows,Helfenbein & Newnam Funeral Home, P.A. part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CARDO pulmonary ARREST

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28e-f show

Director

Funeral

Be Completed by

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, I'm Medical Existing at must be tadified at once.

Baltimore, Maryland 21215-0036

the Maryland

To the numbers after death.
within 24 hours after death.
To the Funeral Director: After this

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

resulting in death)	Due to (or as consequ	ACCURATION OF THE PROPERTY OF				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Py tured The Due to (or as a consequence of the	rsim	eurypu			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1	death 3 Ectopic pregnancy		23d	Date of deliver	y Day Year
Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying cause given in Pr		Did tobacco use 1 ☐ Yes 2 ☐ N		
				Was an 2 autopsy performed?	4b. Were autop prior to com death? 1 \(\sum \text{Yes} \) 2	sy findings available pletion of cause of
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☑		ace of Death (Check of Nursing Home 5		Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury at Work? M 1 □ Yes 2	28d. Desc	ribe how injury o		
3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28f. Locat City o	ion (Street and N or Town, State)	lumber or Rural	Route Number,
29a. Certifier 1 ☐ Certifying Phy cone) 1 ☐ Certifying Phy 2 ☐ Medical Exam	vsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death occurred at the time, date ion and/or investigation, in my opinion,	and place, and due to death occurred at the t	the cause(s) and time, date and pla	d manner as sta ace, and due to l	ted. he cause(s)
29b. Signature and title of certifier	alal Jo M. S	29c. License numb			igned (Month, D	ay, Year)
30. Name and address of person who of Tolin C. ARRI	ompleted cause of death (Item	1 2 11 1 076	est, CK	fur for	m ne	121620
Of Date (Hard (March Day (Canal)	00 Di					

DHMH 17 Rev 1/2001

State

Registrar

JOLM C. ARRATS M. 774, M. /)
31. Date filed (Month, Day, Year)

32. Registration

APR 0 2 2004

State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:05 PM Silver Joseph Gsell, Jr. March 10 2004 /Medical 4c. County of Oeath 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Chester River Hospital Center Chestertown Kent If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1∭M 2□F Director 218-34-3118 April 18. 1938 Delaware 70 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show event, the Medical Examinar must be notitied at 1 TYes 2 □ No Director MD. Kent Worton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ō or Items 23e 24703 Lambs Meadow 21678 Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) N Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ 3 Widowed 4 Divorced White 'naturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Caretaker Ed Fry marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) of Health and Mental H litem 27 is marked ott r other traumatic even Be Silver Joseph Gsell, Sr. Alice Delmar Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie L. Gsell P.O. Box 571 Chestertown, Md. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery 3/13/2004 Chestertown, Maryland 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Md. 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 10 1s resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fulsease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): the attending physician and for use as the burial. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? I Director: After to d in by the funera 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funerel 6 1) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D21313 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 415 Washington Avenue, Chestertown, Maryland 21620 Dr. Kin K. Wun, M.D.

State Registrar 31. Date liled (Month, Day Reg) 1 1 200 4 32. Reg frar's Signature

DHMH 17 Rev 1/2001

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	Funeral Director		5. Social Security Number 6. S 214-09-0858	ex 7. Age	(In yrs. last bii 91	rthday) _ Yrs.		Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Sept. 3,	h v, Yeer) 1912	Co	thplace (Stete ountry) ryland	or Foreign
- Al	D		Usual Residence of Decedent		10c. City, Tow						3050.37	1312	1 24.	10d. Inside C	ia. Limia.
	death with the Maryland ms 23a or 28a-f show	ō	10a. State 10b. County Maryland Washing		Hage:										2 ☐ No
	r 28a-	irect	10e. Street and Number	LOII	nage	ISCO	10f. Zip (Code				10g. Citizer	n of What Co	ountry?	
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330	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. Brootchart: If them 27 is marked other than "natural; or Rems 23e or 28e-f show any injury or other traumatic event, the Modical Examinat mast he notified at ODGs.	by Funeral Directo	11. Maritaf Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 35100 If Yes, Give Year or Dates:			/as Decede Yes, speci		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		Bfack, Whit	enican Indian, e, etc. nite	
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Ê	Peges nent of int: If i		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specil				n Men			April	L 10,04	Hage	rstow	n, Mary	land
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cords, P	requires that the death certifica een signed by the attending pt hould be detached for use as t	by	Part II. Other significant conditions of	ontributing to death but	t not resulting i	n the und	derlying ca	use give	n in Part I.		11	bacco use		the cause of cobably 4 🔲	
O	> D 70	ompleted									24a. Was	an 2	4b. Were at	itopsy findings	available
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			1 - For State Registrar	State of Ma	aryland / Dep: <i>Ce</i>	artment of H rtificate of I	lealth and M Death		ene2 () () (4	13254
			1. Decedent's Name (First, Middle, Las	(t)	-			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		SHIRLEY LORRAIN	E HEWET	T			APRIL	6 2004	11:25 P ^M
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	Funeral Director		214-32-4367	DM OFFI	e (In yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEPT. 1,	Year) 9. Birthp Cour 1934 WEST	place (State or Foreign htry) VIRGINIA
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits
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Ē	d 2 should be th and Mental 7 is marked of traumatic ev	욘	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	ELSIE H		City or Town, State, Zip	Code)
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ē,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City or To	
٤	Pages nent of i int: If it		1 🔀 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify			-		/2004 5	HARPSBURG,	MARYLAND
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of internal Service Lice		22	2. Name and Addres AST FUNER	S of Facility	7606 01d	National l	Pike
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1	Hy		30. Name and address of person who Michael MC 31. Date filed (Month, Day, Year)	completed cause of d	eath (Item 23a) (Type,	Print) Media	(Ciron	ous b	Zrenhun	mo
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			Registrar 1. Decedent's Name (First, Middle, La	st)			- Timouto				2. Date of Deat	ng. No.		3. Time	of Death
	Physic		_								MARCH	Day	2004	3	40 AM
	/Medi Examir		Sylvia Susan An: 4a. Fecility Name (If not institution, giv		r)		4b. City, T	own, or	Location of		MICCE	-	y of Deeth		
			Washington Count						town			Wash	ingto		
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	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside	City Limits
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/lai	should be nd Mental marked o	10	Stewart A. Hill						Ger	neva 1	Mercer 1	Hill			
Maryland	and and sum		19a. Informant's Name/Relationship (19						Route Number,				05.44
	and sellth m 27		Deanna E. Young/	Daughter	20h Bloom	0075 CHR	VISION (Name		ne, F		ng Wate				a 2541
0	ges 1 It of F If ite or ot		20a. Method of Disposition **Description**	Removal from Stat	cemet	ery, crer	natory or oth	er place		Da		20c. Location	•		
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Bal	permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Service Licer	1/ 7							yıas A. N. Hagei				
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	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	N .		, ,			, ,			Interval B	etween
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90,	ate be executed hysician and the burial-transit	E	resulting in death) Last	∕i `	s a consequence	, .	. بيا م	C			. 7	> A =	. !	(//)	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d. CWE	مار ک	54-	uctore	<u> </u>	0 Jul	ON AT	7	3V/3	ی	ye	20.0
9	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy				3200		•		1	ii Looti	
Вох	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal deal at time of death		Ectopic pred						ite of delive onth	ry Day	Year
P.O.	the dr y the iched	Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown		3_	Olifer (Spec								
	uires that the de signed by the a id be detached f		Part II. Other significant conditions of	ontributing to death	but not resulting	in the u	nderlying cau	ise givei	n in Part I.		23e. Did tob	acco use con	tribute to th	e cause of	death?
Records,	w require: been sig should be	Completed by	4001 PV4	42/21	Per	UAL	- F	AL	20	2	1XYe	s 2 🗆 No	3 Prob	ably 4	Unknown
000	law requ as been 2 should	plet	D'abetes	11	Fix Te.	Pr	tope	0(0	43		24a. Was an		Were autor	sy finding	s available
	ici an : The lav certificate has rector, page 2	mo:	POR WOUN	el Ho	4/11/9		13000				autopsy perform	ed?	prior to con death? 1 Yes		cause or
ita	ian: ortifica ctor, j	Bec	25. Was case referred to medical examiner?		11110				26. Place	of Death	Check only one				
) \(\)	hysic his ce	2	1 ☐ Yes 22 No	Hospital: npa		utpatien	t 3 DOA	Other	r: 4 □ Nui	rsing Hom	e 5 ☐ Resider	nce 6 Oth	ner (Specify)	
ū	ing P Viter t unera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. D te of In (Month, D	jury 28b. Pay Year)	Time of Injury		C. Injury Work			3d. Describe how	v injury occur	red		
Sio	tend death for: /	icat	2 Accident investigation 3 Suicide 6 Could not be		-i A. b	4	М		es 2 🗆 N		16 1				
Division of Vital	after Direction by	Certification:	4 Homicide determined	288. Place of I	njury - At home, etc, (Specify)	rarm, str	eet, factory,	office		28	If. Location (Streetly or Town,		oer or Hura	Route Nu	mber,
	spitel cours neral filled		29a. Certifier Certifying Ph	ysician: To the bes	at of my knowledg	oe. death	occurred at	the time	a. date and	d place, an	nd due to the car	use(s) and ma	anner as st	nted	
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examona)	niner: On the basis and manner s	of examination a	ind/or inv	estigation, in	n my opi	nion, deat	th occurred	d at the time, da	te and place,	and due to	the cause	(s)
	To the To the To the Comp	×	29b. Signature and title of certifier	11			29c.	License	number		29	d. Date signe	d (Month, L	Dey, Year)	. /
•	\D		Atm.	Helm	MD		1) ;	279	149		Marc	h &	3 2	204
	4. 10		30. Name and address of person who	completed cause of	death (Item 23a) (Туре,	Print)			7 /	1	1		1	
-	ノ		Dr. Hallebling	1/110 p	Ikdical		ange	un	Rd	. 1-	try. M.	1 21	747		
100	Sta	ite	31. Date filed (Month Aar Year)	1004 32. Pegis	trar's Signature	A									

			1 - For State Registrar	State of Marylar			of Health of Deatl			ene 200L	13256
	Physici /Medic		Decedent's Name (First, Middle, Las KATHRYN CORD	REY HILL					2. Date of Death Month APRIL 9	Day Voca	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give SNOW HILL NURSING 5. Social Security Number 6. S	& REHABILITAT				HILL	8 Date of Righ	4c. County of Dear	ER
	Funeral Director		214-10-7928 Usual Residence of Decedent	□M 2ØF 86	Yrs.	Months D	ays Hours	Min.	8. Date of Birth (Month, Dey, 1 June 22,	Year) 1917 Ma	thplace (State or Foreign puntry) ryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28e-f show any injury or other traumatic event, the Mudical Examiner must be notified at once.	rector	10a. State 10b. County Maryland Worces 10e. Street and Number		ty, Town or Lo Snow Hi		de		100	g. Citizen of What Co	10d. Inside City Limits 1 K Yes 2 □ No
	death with	Funeral Director	430 W. Market S	12. Was Decedent Ever in U	l.S. 13. V	21 Was Decedent	863	origin? (Spec	cify Yes or No-	USA 14. Race - Ame Black, Whit	orican Indian,
-0036	hours after turel', or It	by	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced 15. Decedent's Ed	1 □Yes 2X No If Yes, Give Year or Dates:	1	1 ☐ Yes 2%☐	No Specify			Specify: W	hite
Maryland 21215-0036	d within 72 giene. er than "ne the Mudic	Completed	(Specify only highest gra		(Give life. L	kind of work d DO NOT use n emaker	ccupation lone during mo etired)	ost of workin	9	Domestic	
yland	ould be file Mental Hy varked oth	To Be (Cordrey			1	Lula	(First, Middle, Ma Oliphan	t	
	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship (1) Betty L. Chew/ni 20a. Method of Disposition	.ece 20b. F	947	71 Rum	Ridge 1	Rd., I	Delmar, 1	City or Town, State, 2 MD 21875 Oc. Location - City or	
altimore,	mit. Pages partment of sortant: If it injury or c		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21 Signature of Funeral Service Licen	Pariover from State	emetery, cren arsons	Cemete	ry	4/12	2/04	Salisbury	
ä	permi Depa Impo any is		23a. Pert1. Enter the disease, or compshock, or heart failure. List only	dications that caused the deat	P 5	01 Sno	w Hill	Rd.,	Salisbu	ry, MD 218	ASSOCIATION 304 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Uru Su Due to (or as a conseq	psis	1	0				Onset and Death
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseq	uence of):	O (VVC					
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a conseq	uence of):						
P.O. Box 6	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. It yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregn				23d. Date of deli Month	ivery Day Year
	w requires that been signed b should be deta	ed by P	Part II. Other significent conditions of	ontributing to death but not res	ulting in the un	iderlying caus	e given in Part	f.	23e. Did toba	cco use contribute to	
Division of Vital Records,		Completed			-				24a. Was an autopsy performe	death?	topsy findings available completion of cause of
of Vit	Physicier this certif al directo	To Be	25. Was case reterred to medical exeminer? 1 Yes 2 No 27. Manner of Death		ER/Outpatient		Other: 4XX	ursing Hom		ce 6 Other (Spec	:ify)
vision	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		Injury	М	Injury at Work? 1 Yes 2]No	Bt. Location (Stree City or Town,	et and Number or Ru	ral Route Number,
ō	ospital or hours afte uneral Dii		29a. Certifier 1 Certifying Ph	ysicien: To the best of my kno	wledge, death	occurred at th	ne time, date a	nd place, ar	nd due to the caus	se(s) and manner as	stated.
	To the H within 24 To the Fu completel	Medical	20h Signature and vitle of certifier	niner: On the basis of examina and manner stated.	ition and/or inv	29c. Lic	ense number			and place, and due Date signed (Month	` '
2			30. Name and address of person who o	completed cause of death (Item	n 23a) (Typ e, F		RAD	BARA	1. ~ ~	4-9-	04
)억	Sta	te	160 4- V/M 31. Date filed (Month Day, Year) APR 13 20	Ket St. 3		como	ke,	M	D 218	5/	
	Registr		APR 1 3 20	104	~	japon	~				

			For State Registrar	State of Maryland / De	partment of Health and Nertificate of Death		giene2 () () [13257
	Physici		1. Decedent's Name (First, Middle, Last) Catherine M. Henry			2. Date of Dea April	Day Yee 3, 200	
	/Medic Examir	_	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of De	ath
	Funeral Director		Berlin Nursing Home 5. Social Security Number 6. Sex 219-07-0098		Months Davs Hours Min.	8. Date of Birth (Month, Day May 10,	h 9. B	rirthplece (State or Foreign Country) MD
	ne Maryland 8a-f ehow	ector	Usual Residence of Decedent	r Berlin	Location 10f. Zip Code		10g. Citizen of What	10d. Inside City Limits 1 ☑Yes 2 ☐ No
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or itema 23a or 28a-f ehow other then "naturel", or itema 23a or 28a-f ehow event, the Medical Exardinatinal be mailied at	by Funeral Director	Isaiah Fassett Apt: 1. Marital Status 1. Never Married 2. Married 3. Widowed 4. Ovorced	S., #20 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Yoo If Yes, Give Year or Dates:	21811 3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		U.S.	nerican Indian,
Maryland 21215-0036	72	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (G	cedent's Usual Decupation ive kind of work done during most of work b. DO NOT use retired) Beautician	sing	16b. Kind of Busines	mployed
yland 2	should be filed within and Mental Hygiene. marked other then umatic event, the M	To Be C	17. Father's Name (First, Middle, Last) George "Sim" Henry		Elsie M	ae Britt		7.041
Baltimore, Mar	es 1 and 2 sof Health ar of Health ar I item 27 le r other trau		19a. Informant's Name/Relationship (Type Lorraine Henry/sis: 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re 14 □ Donation 5 □ Other (Specify)	ter-in-law 2463	ailing Address (Street and Number or Rui 30 Deal Island Rd., sposition (Name of crematory or other place) nel UMC Cemetery 4/	Dames C		D or Town, State
	Permit. Page My Department important: if important: if important important impor		21. Signature of Funeral Septice License 23a. Pri1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not	22. Name and Address of Facility Lewis N. Watson Fu 1618 West Rd., Sal enter the mode of dying, such as cardiac	isbury, or respiratory ari	MD 21801 rest,	Approximate Interval Between Onset and Death
8760,	ite be executed sysician and he burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
.O. Box 6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of c Month	lelivery Day Year
s, D	w requires that the second of	þ	Part II. Other significant conditions con	ntributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
I Record		Completed	Essential Diabetes V.	Rellitus Ty	ne II	24a. Was a autop: perfor 1 Tes	med? prior t	
Vital	Physicien: The this certificate ral director, pages	Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	26. Place of Dea		ne) lence 6 □Other (S)	pecify)
ion of	ding After fune	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Injur	e of 28c. Injury at		now injury occurred	
Division	ospitei or Attend hours after death uneral Director: ily filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	Street and Number or vn. State)	Rural Route Number,
	Hospitel or 24 hours afte Funeral Dir letely filled in I	dical (eath occurred at the time, date and place r investigation, in my opinion, death occu			

Henry, Catherine

Gregorio Belloso, MD

D 29505

29d. Date signed (Month, Day, Year) 04-03-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5302 Chinaberry Dr. Salisbury, MD 21801

31. Date filed (Month, Day, Year)

29b. Signature and title of certifler

32. Registrar's Signature APR 0 8 2004 >

29c. License number

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:33 am VIRGINIA HORN NELLIE 04 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington Hagerstown Coffman Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 3,1909 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2FXF Yrs. 95 Pennsylvania 215-20-8121 Director Usual Residence of Decedent e filed within 72 hours efter deeth with the Maryland bi Hygiene. other than "natural", or flems 23s or 28s-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylen Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified at 1 XYes 2 ☐ No Funeral Directo Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21742 1304 Pennsylvania Ave. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4or 5+) Maryland Ribbon Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David C. Horn Emma Staley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1130 Hamilton Blvd. Hagerstown, MD Anna F. Stup/Niece 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/16/2004 Hagerstown, MD Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Ent.: the disease, or complication. 21 traused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 1 year. disease or condition resulting in death) Examiner Physician/Medical Examiner use es the buriel-trensit or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2/200 1 Y63 1 ☐ Yes 26 No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 40 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending To the Hospital or Attanding within 24 hours efter deeth.

To the Funeral Director: Aft completely filled in by the fur 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier en D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 mill Street Halestern MD21740. 31. Date filed (Month: Day 32. Registrar's Signature State Paleir

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAMFND ITEM #29d PER PHY C830 4/27/04 Sufficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 1 Day 2004 Year **Physician** LAWRENCE EDWARD HOLMES, JR. 6:29P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE SOUTHERN MD. HOSPITAL CENTER CLINTON 7. Age (In yrs. last birthday)
6 1 Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 4 3 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 214-42-2727 **€**Director PA. Usual Residence of Decedent the Marylan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f shows the state of the state WALDORF MARYLAND CHARLES 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 U.S.A. 3240 DUNBRATTON COURT by Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic event, the Medical Examinar Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ត 1 ☐ Yes 2♥ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry timore, Maryland 2121 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN 12 NATELCO ELEC.CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi and Mental F is marked ot LAWRENCE E. HOLMES RITA EVA PINCOTTI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 HEATH M. HOLMES-SON 9801 LARSON PL. WALDORF, MARYLAND 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State '4 □Donation 5 ♥ Other (Specify) ENTOMBMENT TRINITY MEM.GARDEN 4-7-04 WALDORF, MARYLAND MO0479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) phalor **Physician** /Medical Due to (o) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2/D No 1□ Yes Division of Vital After this certification funeral director, Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Philtician. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALDORF.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 7 2004

32. Registrar's Signature

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State of Man	land / Department of Health and Mental Hygiene 2 🖺 🦳 📗

13260 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John H, Harris 8 2004 8:25 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Nursing Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months XXM 2 F Director 220-05-0040 March 22 1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; If item 27 is marked other than "netural", or items 23e or 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or Items 23e or 28a-f show other treumatic event, the Medical Extenings regard to notified at 1 Yes 2 No Maryland Anne Arundel Direct Annapolis | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 705 D Newtowne Drive 21401 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:Black þ 1 ☐ Yes 2 ☐ No Specify: 3 ™Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Truck Driver Lumber Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ John H. Harris Sr. Margaret Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Edwards (Sister)
20a. Method of Disposition 705 D Howtowne Dr. Annapolis, Md. 21401

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from State Fowler UM Church 4 □ Donation 5 □ Other (Specify) Cemetery Name and Address of Facility 3/25/04 Annapolis, Md. 21. Signature of Funeral Service Licenses 23a. Pant. Enter the disease, or confidential caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, any ir Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emensia /Medical Due to (or as a consequence of) Examiner frank, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Lary attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No the Hospitei or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 vursing Home 5 Residence 6 Other (Specify) ို this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ţ 1) 41978 29d. Date signed (Month, Day, Year)
3-19-2004

mischille Rd A312 Bowle M./ 29b. Signature and title of certifie 30. Note and address of person who completed cause of death (Item 23a) (Type, Print)

Vade Completed Cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Piease Type or Print in Black indelibie ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate o	f Death		Reg. No.	104	13261
	Dhusisi		1. Decedent's Name (First, Middle, Lest)					2. Dete of D Month	eeth Day	Year	3. Time of Death
-	Physicia /Medic		William Laure	nce Hicks				March		2004	12:45 am
	Examin		4e Fecility Name (If not institution, give s	street end number)			4b. City, Town,	or Location of Dee	th 4c. County	of Deeth	
	Funeral Director		212-05-6900	er- Genesis E 7. Age (In yrs. IM 2 F 98	lest birthday)	If Under 1 Yea Months Day		ore Irs. 8. Date of 8 in. June	Balt	9. Birthpli Count Mar	e ace (State or Foreign cyland
	pua *	ł	Usuel Residence of Decedent 10a. Stete 10b. County	10c. Ci	ly, Town or Loc	ation				10	Od. Inside City Limits
	the Maryl 28e-f eho	ector	Maryland Baltim		ckeysv:				10g. Citizen of		1 ☐ Yes 2 ☑ No
	a 23e or	Funeral Director	3 Fire Fly Circl	E 12. Was Decedent Ever in U	E 13 M	210	30	(Specify Ves or N	United		es
0050	filed within 72 hours after death with the Maryland Hygiane. ther than "naturel", or teme 23e or 28e-f ehow ent, the Medical Examiner must be notified at	Ď	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2 N	Specify:	(Specify Yes or N erto Rican, etc.)		ck, White, e	etc.
Maryland 21215-0020	d 2 should be filed within 72 h h and Mental Hygiane. 7 ie marked other than "natu treumatic event, the Medica	Completed	15. Decedent's Educ (Specify only highest grede Elementary/Secondary (0-12)	cetion e completed) College (1-4or 5+)	(Give k		upation e <i>during</i> most of v ed)	vorking	16b. Kind of B		ustry
7	be filed withintal Hygiane. Ind other than event, the M		17. Fether's Neme (First, Middle, Last)			welder_	18 Mathar's N	lame (First, Middle	weld		
au	S E S S	Be	17. Fettlet's Nettle (1731, Middle, Last)					e Trotte:		10)	
2	d Me	ဠ	Calvin Hicks 19a. Informant's Name/Relationship (Type	no Print)	10h Mailin	a Address /Stra		Rurel Route Numb		State Zini	Codel
Ma	s t and 2 should f Health and Men item 27 ie marke other treumetic							Laurel, N		State, Zip	3000)
ē,	s 1 and 3 if Health item 27 other tr	ŀ	Joyce Weesner/ n	20b. P	Place of Dispos			Date	20c. Location -	City or Tov	vn, State
Baltimore,	Page nent o int: If i		1 Burial 2 Cremation 3 R 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State	Anne'	s Cemet	ery	3/26/04			
Ba	permit. Departn Importa eny injt		De Scott 1	Conjuitable	1	47 Duke	of Glou	cester S	t. Annap	olis,	l Home, Inc mD 21401
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the deat e cause on eech line.	h. Do not ente	r the mode of dy	ring, such as card	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner	<u>.</u>	Immediate Cause (Final disease or condition resulting in death) a	Due to (o	Mull or as a consequ		masar	der de	lul	i	nau.
·	axecutad n and iai-transit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events	Due to (o	r as e consequ	uence of):					
x 68760,	eath certificate be axecuted attending physician and I for use as the bunal-transit	Medical	Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequ	ence of):					
Вох	atten Ifor u	clar						T		1	
, P.O.	requiras that tha death een signed by the atter hould be datached for u	by Physician	Part II. Other significant conditions confined by Agriculture Agri	ributing to death but not resi	ulting in the un-	derlying cause g	iven in Part I.		Yes 2 No		ably Unknown
of Vital Records,	aw requiras is been sig 2 should b	Completed b							s an autopsy ormed?	avai	re autopsy findings lable prior to apletion of cause eath?
æ	The law ata has b page 2 s	E						***	Y60 24 NO	10	Yes 2 No
ita	ician: The	Be	25. Was case referred to medical examiner?		1871 1		26. Place of D	eath (Check only	one)		1
<u></u>	<u>v</u> 5	٥	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3LI DOA		Home 5 ☐ Res	idence 6 □Oth	er (Specify)	
ion	After fune	ation:	27. Menner of Death 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj W M 1[uryat ork?]Yes 2∐No	28d. Describe	how injury occur	red	
Division	tal or Attenders after death bit Director; ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,
	ne Hospi n 24 hou ne Funer plataly fill	edical	29a. Certifier 1 N Certifying Physical Check only one) 2 Medical Examin	iclan: To the best of my knower: On the basis of examinat and manner stated.	wledge, death of tion and/or inve	estigation, in my	opinion, death oc	ce, end due to the curred at the time,	date and place,	and due to t	the cause(s)
D	To t To t	Σ	29b. Signature end title of certifier MULLIUM	numal		054	ise number 15/8		3-23-		
			30. Neme end eddress of person who/cor 5(d) WW/WW/BU	npleted ceuse of death (Item	1 23e) (Type, P	(rint)	Maria Mar	tha C. Rayn	nundo MD		
	Stat	е	31. Dete filed (Month Pay Peer) 5 2	32. Red strer's Signa	ture	hack .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARTIN DANIEL 5, HEIDERMAN 2004 April 0418 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Easton Talbot Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) Birthplece (State or Foreign
Country) 1**X** M 2□ F Yrs. 213-52-7091 55 DEC. 14, 1948 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 1 Yes 2 No Director MD TALBOT WITTMAN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22860 POT PIE ROAD 21676 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed)

ADJUDICATION

12 17. Father's Name (First, Middle, Last)

GEORGE SHERLOCK HEIDERMAN

Elementary/Secondary (0-12)

FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname)

PINKY TRUSSEL

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

MARY ANN HEIDERMAN/WIFE 22860 POT PIE ROAD, WITTMAN, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 04/07/2004 STEVENSVILLE, MD

21. Signature of Funeral Service Licensee nar

22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD

23a. Part1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on some line. Immediate Cause (Final , ease

resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Premator wing di	Š
Due to (or as a consequence of):	
Pulmonam Ritrosis	
Due to (or as a consequence of):	

Phellmonia Due to (or as a consequence of):

Approximate Interval Between Onset and Deeth

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

College (1-4or 5+)

4☐Pregnant at time of death

3 DEctopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performe

1 Yes 265 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 ☐ Yes 2 € No inpatient 2 ER/Outpatient 3 DOA 28a. Dat. of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier t 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel

3 Suicide

4 - Homicide

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0059762

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Memorial

State Registrar



East

ORIGINAL

filed within 72 hours after Martin Heiderman Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, The Media once. **Physician** /Medical Examiner

Physician

Funeral

Director

or 28a-f ehow

in than "natural", or Items 23a or 28a-f eho the Wedical Examinar must be notified at

Be

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Examine

Physician/Medicai

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Completed

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Certification: To

Medical

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attending physician and for use as the burial-trai

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death.

within 24 hours after deat To the Funeral Director:

Hospital

To the

After th funeral

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filled in by

c. mpletely

death

or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records,

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Renova Bryan Henry March 20 2004 7:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗗 F 416 28 0909 81 Director March 22,1922 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ahow the Medical Examiner must be notified at 1 TYes 2X No MD Howard Ellicott City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3929 Hawthorn Road 21042 United States 14. Race - American Indian, Black, White, etc. or Iteme 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes ZX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 Widowed 4 Divorced White "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bessie Chancellor George Clark Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 1s
any injury or other treu Malcolm E. Henry/Husband 3929 Hawthorn Road Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Gard. 3-24-2004 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Stem 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** SUB dwal hemotoma veeks /Medical Due to (or as a consequence of): **Examiner** Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Records. P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No rs after deam.

red Director: After this cere...

by the funeral director, pr Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 COther (Specify) ↑ Soice 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 0700A 2 Accident Yarch 20 2004 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours aft To the Funerel Di completely filled in Lchris 1x 6601 N. Charles St Batt, Mr 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number march 20, 2004 1)25205 who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 21208 6700 3mc 32. egistrar's Signature 31. Date filed (Month, Day, Year) State MAR 23 2004 Registrar

120/04 27:00 Am

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth April 2004 Arnold 14 Holston 9:00 AM 4b. City, Town, or Location of Deeth 4a Fecility Neme (ff not institution, give street and number) 4c. County of Deeth 6336 Cedar Lane Room 187 Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 2,1933 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 405 38 3244 Yrs. 71 Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 1 Yes 2 No Howard Columbia 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number 6336 Cedar Lane Room 187 21044 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 12 Yes 2 No If Yes, Give Yeer or Dates: 1951-55 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Manager Dept. of Defense 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Holston Ora Carroll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 6815 Haviland Mill Road Clarksville, MD 21029 of Disposition (Name of Date 20c. Location City or Town, State Nancy Talbot/Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4-15-2004 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 wo 23a. Part1. Enter the disease, or complications that cau et the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of):

Physician /Medical Examiner

Depertment of important: if it any injury or c

Physician

/Medical

Examiner

Director

Funerai

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Completed

Be

MD

Funeral

Director

Peges 1 end 2 should be filed within 72 hours after daath with the Marylend nent of Health end Mental Hygiene.

Int: if item 27 is marked other than "natural; or items 23s or 28s-f show ury or other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Completed by

attending physician and I for use es the bunal-transit ed by the a detached f After this certificate has been significate has been significated and a should the second the second second the second se Be the funeral director, 2 Certification: death.

The lew requires that the daath certificete be executed

or Attending Physician:

Director

To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the

Division of Vital Records, P.O. Box 68760,

5 Pending investigation

6 Could not be determined

25. Was case referred to medical

29b. Signature and title of certifier

1 ☐ Yes 2 ZXNo

27. Manner of Deeth

1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

ANKAI

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. CHYONIC ATRIAL FIBRILLATION

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA

Date of Injury (Month, Day Year) 28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 25 No

1 Yes 2 No

24a. Was an autopsy performed?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the best of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner steted. 29d. Date signed (Month, Day, Year) 29c. License number

of deeth (Item 23e) (Type, Print)

April 14, 2004

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

6003

State Registrar

edical

32. Registrer's Signature 31. Dete filed (Month, Day, Year) 1 5 2004

ORIGINAL

DHMH 16 Rev 6/95

		1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of I	Health an	d Mental Hy	giene	2001	13265
Physic		Decedent's Name (First, Middle, Last) Harry Richard I	Jani fee	-			2. Date of De Month March	eath Day	2004 Yeer	3. Time of Death
/Medi Exami		4a. Fecility Name (If not institution, give s Chester River Hospi	treet and number) ital Center			tertown	Death	4c.	County of Deat Kent	
Funeral Director		5. Social Security Number 6. Sex 218–48–6895	7. Age (In yrs. 56		If Under 1 Year Months Days		Min. 8. Dete of Bit (Month, Did)	1948	CQ	hplace (State or Foreign untry) Lena, MD
he Maryland Ba-f ehow	ector	10a. State 10b. County Maryland Kent	10c. Ci	y, Town or Lo Galena	à					10d. Inside City Limits 1 ☐ Yes 🌠 No
th with t 23a or 2 ust be n	Funeral Director	13910 Augustine Her	man Highway		10f. Zip Code 2163	35		10g. Citiz	zen of What Co	untry?
1215-0036 within 72 hours after death with the Maryland ane. than "natural", or Items 23s or 28s-f show he Medical Examiner must be notilized at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	l1	Was Decedent of I I Yes, specify Cub □ Yes 2 No		? (Specify Yes or No uerto Rican, etc.)		4. Race - Ame Black, White Specify: Wh	
Maryland 21215-0036 td 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done OO NOT use retire	pation during most of d)	working		al Desi	,
aryland 2 should be filed and Mental Hygis marked other umatic event, it	To Be C	17. Father's Name (First, Middle, Last) James Clifton Hanif				Anna Ma	Name (First, Middle Ae Wallace	, Maiden S	Sumame)	
		19a. Informant's Name/Relationship (Type Carol Ann Hanifee / 20a. Method of Disposition	Wife	PO Bo	ox 238, G	Galena,	Rural Route Numb Maryland Date	2163		
Page Page Tent o		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature 1 Funeral Service License	Gal	lena Ce	matory or other pla metery Name and Addre	03	3/30/2004		ena, Ma	
Denmit. Departition of the popular o		23a. Part1. Enter the disease, or complic					ein & Newn reet, Mil	am Fi lingd	uneral ton, MD	Home, P.A. 21651
Physician /Medical		shock, or hadr failure. List only one immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	uence of):	ny A	ng, such as car	Dist	rrest,	\$	Approximate Interval Between Onset and Death
ate be executed thysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq							Oallum
BOX 6	Physician/Medic	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 U Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3 🗌	Ectopic pregnancy Other (specify)	у		23	3d. Date of delive Month	rery Day Year
ecords, P.O. law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions cont	ributing to death but not resi	ulting in the un	derlying cause giv	ren in Part I.		obacco us		the cause of death?
The lay	Completed						24a. Was autop perio 1 Yes	rmed?	24b. Were autroprior to condeath?	opsy findings available ompletion of cause of
O & = =	on: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Mann of Death 1 Natural 5 Pending	espital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Yeer)	ER/Outpatient 28b. Time of Injury	3□ DOA Oth	er: 4 🗆 Nursin	Death Check only of g Home 5 ☐ Residence 1 28d. Describe to	dence 6		<i>fy</i>)
OVISION or Attending after death. Director: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	M 1 🗆	Yes 2 No	28f. Location (5 City or Ton		Number or Rur	al Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physical Examine	cian: To the best of my kno er: On the basis of examinal and manner stated.	wledge, death tion and/or inve	occurred at the tirestigation, in my o	me, date and pla pinion, death or	ace, and due to the occurred at the time,	cause(s) a date and p	nd manner as s lace, and due t	stated. o the cause(s)
To t withi To t	Σ	29b. Signature and title of certifier	JR		29c. Licens	3605	4	29d. Date	signed (Month,	Day, Year)
			han, MD 120	Speci	PD Sut	O II o	hestertai	nHe	2116	10
Sta Registr		31. Date filed (Month, Day, Year) MAR 3 U	32. Registrar's Signar	ture	Charles					

State of Maryland / Department of Health and Mental Hygien 👂 🛭 🗎 👢 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2004 Nevin Lee Johnson Sr. 549 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex 14 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Oct. 13, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 77 212-24-3236 Director Yrs. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avant, the Medical Examiner must be notified at Director Md. 1 Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20610 Emerald Dr. "natural", or Itams 23a 21742 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked othar than "natural", or Ita 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 45-47 1 ☐ Yes 2 🛣 No Specify. þ White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreman Furniture Mfg. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul W. Johnson Sr. Margaret A. Leatherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 si if Health an itam 27 is r Ruth E. Johnson (Wife) 20610 Emerald Dr. Hagerstown, Md. 21742 20b. Place of Disposition (Name of commetery, crematory or other place)
Cedar Lawn Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot 1 X Burial 2 ☐ Cremation April 12. 3 □Re Hagerstown, Md. Depation 5 ☐ Other (Specify) 2004 Signature of Funeral Service L 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 6 /Medical Due to # is a consequence of): Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transil attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed? certificate 2 No 1 ☐ Yes 2 40 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 Outpatient 1 Inpatient 3 DOA this After thi funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury . Injury at Work? 28d. Describe how injury occurred Certification: 1 atural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SH-UT! 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 111 31. Date filed (Month, Day)

DHMH 17 Rev 1/2001

State Registrai

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 004

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month 3. Time of Death **Physician** ALVIN ABRAHAM JOHNSON APRIL 12, 2004 /Medical 6:42 AM 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CHARLES COUNTY NURSING & REHABILITATION CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) APRIL 7, 1935 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 ☐ F Yrs 217-28-8506 Director MARYLAND Usuel Residence of Decedent with the Merylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits frems 23s or 28s-f sho iner nast be notified at 1 Ves 2 □ No Director MARYLAND CHARLES **NANJEMOY** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4050 TIMS PLACE 20662 Funeral UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify à Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Be Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
7TH GRADE College (1-4or 5+) SUPERVISOR / TRUCK DRIVER BUILDING SUPPLY CO. 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) ALONZO JOHNSON ANNA NORRIS JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAMONA J. DIGGS / DAUGHTER 3612 STONESBORO ROAD, FORT WASHINGTON, MARYLAND 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. HOPE CHURCH CEMETERY 4/17/2004 NANJEMOY, MARYLAND 21. Surfature of Funeral Social Licensee 22. Name and Address of Facility THORNION FUNERAL HOME, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1.4.4.

236. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1.4.4. Approximate Interval Between Onset end Death **Physician** NASOPHARYNGEAL CARCINOMA Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): ending physiclan are use es the buriel Division of Vital Records, P.O. Box 68760 Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes NO 1 ☐ Yes 2 ☐ No Be (25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpetient Certification: To 1 Yes 2 No Other: 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number and address of person who completed cause death (Item 23e) (Type, Print) 102 PAUL Mellow CT WALDORF MO 20602 ASHVINKUMAR 31. Dete filed (Month, Day, Year) State Moder APR 1 5 2004 Registrar

	-		Fee	State of Marylan				Mental Hyd	iene	
			1 - For State Registrar			rtificate of I			eg. No. 2001	+ 13268
	Physici	8	1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month	th Day Year	3. Time of Death
	/Medic Examir	cal	Hazel Mae Jocu 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deal	March		04 5:15 Pm
			Genesis Elder	Care- Spa Ci	reek	Annar	polis		Anne Ar	
В	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	9. Bin C 26. 1920	thplace (State or Foreign ountry) Maryland
	p ≥ ∴		Usual Residence of Decedent 10a. State 10b. County		y, Town or La	antica		Dec.	20, 1720	
	Maryla f eho	or								10d. Inside City Limits 1
	r 28a-	Funeral Olrector	Maryland Anne 10e. Street and Number	Arundel Ar	nnapo	10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a c	raiD	412 Washington	Street		21403	3		United S	tates
	Hema Iver.m	nne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (9 in, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am- Black, Whi	
920	al', or	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ② No	Specify:		Specify: W	hite
21215-0036	illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow ith. It a Medical Erainfracmust be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced (Give	ient's Usual Occupa kind of work done of OO NOT use retired	ation during most of wo	rking	16b. Kind of Business	/Industry
7	filed within Hygiene. other then	дшс	Elementary/Secondary (0-12)	College (1-4or 5+)		homemake			own home	e
	be filed ital Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle, A		
Maryland	should b nd Menta marked umatic e	To	John Drury				Helen	(unknow	n)	
Z Z	d 2 sho th and 7 to m traum		19a. Informant's Name/Relationship (T)						City or Town, State,	
	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinat must be notified at once.		George Ellis/s 20a. Method of Disposition	On 20b. Pl	1135 lace of Dispo	O HOLLY sition (Name of Y natory or other place	Road F	didgely,	MD 2166	Pown, State
Ē	Pages ment of I ant: #f tto ury or o		1 Burial 2 Cremation 3 F '4 Donation 5 Other (Specify)	Removal from State	J. 1. 01. 01. 01. 01. 01. 01. 01. 01. 01.	st Ceme			Annapol	
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens	9	22	. Name and Addres	s of Facility	ohn M.	Tavlor F	uneral Home
d			23a. Part1. Enter the disease, or comp	lications that caused the death	. Do not ente	47 Duke	of Glo	ucester	St. Anna	apolis, MD
4	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	A	wilton	10	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	71000	14			
	LAdillilei	J.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to for as a consequ	mice off					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		3.100 017.					
,092	ate be executed hysician and he burial-transit	I Ex	resulting in death) Last	Due to (or as a consequ	ience of):					
6876	physic physic the b	dical		d						
Box 6	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan					23d. Date of del	livery
	e death	sicia	in the past 12 months? 1 🗆 Yes 2 🗖 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
О. О.	that the		9 ☐ Unknown / Part II. Other significant conditions con	ntributing to death but not resu	lting in the ur	ideriving cause give	in in Part I	23e Did tob	acco use contribute to	the cause of death?
Records,	quires n sign	d by	Failure	to turine					s 2□No 3□Pr	1 .
900	law requir as been si 2 should l	Completed	General	Debilit	,			24a. Was an		itopsy findings available
		Сош		-7				autopsy perform 1 Yes 2,	ed? death? A No 1 ☐ Yes	completion of cause of 2 No
Vita	Physician: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	- D/O	Othe		th (Check only one		
10	Phy this	n: To	27. Manner of Death	Table 1	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 X Tursing H	ome 5 Resider 28d. Describe how	nce 6 Other (Special of the control	cify)
Sior	uttendin death. ctor: Aff y the fur	catio	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(WONIII, Day 1 dai)	injury		es 2□No			
Division of	l or At after d Direct I in by	Certification:	4 Homicide determined	28e. Pface of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (Streetly or Town,	eet and Number or Ru State)	ural Route Number,
_	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier Check only 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the timestigation, in my op	e, date and place inion, death occu	, and due to the car rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and mainter stated,		29c. License	number	29	d. Date signed (Monti	h, Day, Year)
)) ()			D5	7028	-	3-29-0	4
	į		30. Name and dress of person who co	empleted cause of death (Item	23a) (Type, F	Print) PLUAVE	SH.23	1 Anna	100/15, MA	D.21401
*	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 3 0 20	32. Registrar's Signatu	ure	act o			1	

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year Physician Monika Jones 2004 March 18 3:05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hanover
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 1901 Pete Lane Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director 1952 51 25 Germany 212-78-6515 Usual Residence of Decedent Ju1v permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" nother than any injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Director Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21076 <u>USA</u> <u>1901 Pete Lane</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2/2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: Specify: German 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Auto Parts Depot Delivery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Weidenbruck ပ Elizabeth Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Jones (Husband) 1901 Pete Lane Hanover, Md. 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran ¹ 4 □ Donation 5 □ Other (Specify) Cemetery Name and Address of Facility 3/24/04 Crownsville, Md. 21. Signature of Funeral Service Licenses Larry & Seen MOSY83 Wm. Reese & Sons MOrtuary, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 2. No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 s has autopsy performe rmeg:/ 2**[2**] No certificate 1 🗌 Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 [Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de Funeral Direct letely filled in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. To the within 24 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, lame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State MAR 2 6 2004

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

	•		Chate of Manufand / Department of Health and A	-	•	5.
			State of Maryland / Department of Health and N 1- Stete Registrar Certificate of Death		ene200	4 13270
			Decedent's Name (First, Middle, Last)	2. Date of Deat		3. Time of Death
н	Physici		Julia Alice Jackson	March	21 200	ear
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of I	
н	LXAIIIII	e.	Genesis ElderCare - The Pines Easton		Tal	lbot
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		098-20-2944 10M 20F 93 Yrs.	NOV. 22		Maryland
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
7	death with the Maryland ms 23a or 28e-f show Finast be rediffed at	ŏ	MD Talbot Easton			1 1 Yes 2 □ No
5	1 the	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of Wha	it Country?
)	h with	a D	22- South Aurora Street 21601		US	A
//	deat deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerfo	ecify Yes or No-		American Indian, White, etc.
98	or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify:		Specify:	2 1
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "netural", or Items 23a or 28e-f show event, If a Maritcal Exertine Energited at		15 Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of Busin	B I O C K
7.	n ne	Completed	(Specify onfy highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing	TOO. PRING OF EGGIN	ood modelly
212	d with giene.	Ho	Elementary/Secondary (0-12) College (1-4or 5+) Domestic		Privat	e Residence
	e filed al Hygi I other vent, I	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M		
ylai	ould be Menta arked atic ev	2	Dave Smiler Sus		arris	
Maryland	2 sho	i	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		1	
	ges 1 and 2 should t of Health and Mer If item 27 Is marke or other traumatic				TUN (V)a 20c. Location - Cit	ryland 21601
Baltimore,	Pages nent of H int: If its iry or of		1 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)	1 11		
턆	그 돈 뿐 글		*4 □ Donation 5 □ Other (Specify) Richards MeM. Park 3/2 21. Signature of Funeral Service Licensee / 22. Name and Address of Facility		=aston	Maryland
Ва	permit. Departimport any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral 510 washington	HOME, P.	/4.	MD. 21613
			23a. Part Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac stook, or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final			Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):			- u.wys
Н	Examiner		Sequentially list conditions. b. Kensel festive			years
	Sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	be execute ician and burial-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			years
760,	sath certificate be executed attending physician and for use as the burial-transit	cal E				
89	ificate g phys as the		U.			
Box	death certifica le attending ph ed for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□Ectopic pregnancy		23d. Date of	,
		sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.O.	that the de ad by the detached	Physician/Medi	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did tob	acco use contribu	ite to the cause of death?
	Se do	β	Part II. Other significant conditions contributing to death but not resulting in the discerning cause given in rare.			Probably 4 Nunknown
Ö	w require been si	etec	A coale	24a. Was an	n Oth Was	e autopsy findings available
Rec	The law ate has page 2 t	Completed	pmerma	autopsy perform	y prior ned? deat	r to completion of cause of the
<u>a</u>		ပိ	25. Was case referred to medical 26. Place of Deat	1 ☐ Yes 2		Yes 2 No
of Vital Records,	Physician: r this certific ral director,	To B	examiner?		nce 6 Other (Specify)
10	g Ph ter thi		27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work?	28d. Describe ho		
io	Attending at death. ector: After by the fune	atic	2 Accident investigation M 1 Yes 2 No			
Division	tal or Attending Physic's after death. al Director: After this co	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town		or Rural Route Number,
	pital		29a. Certifier TS Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the ca	use(s) and manne	or as stated
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
	ro the	₹	29b. Signature and title of certifier 200 29c. License number	29	9d. Date signed (N	fonth, Day, Year)
	- > - 0		DZ5939		3/22	04
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Fa	- MA	N10 = 1
_			LICHAET KOMMY WD 208 IDMFMIND LICHOR	L175	7111 NOT	21601
	Sta Regista		31. Date filed (Month, MAR'an) 4 2004 32. Registrar's Signature		,	
	negisti	aı				

Julia Jackson

			1 - For State Registrar	State of Maryland / D	epartment of F Certificate of	lealth and Mental F Death	lygiene Reg. No		13271
	Dhysici	20	1. Decedent's Name (First, Middle, Last)	_		2. Date of Month	Death Da	y Year	3. Time of Death
	Physici /Medic		William F. Jarrell	Jr.		March		2004	4:45p. M
A STATE OF THE STA	Examir	ier	4a. Facility Name (If not institution, give s	33.71	_	r Location of Death	1	. County of Death	Gl
			Manor Care Nursing 5. Social Security Number 6. Sex		TOWSON day) If Under 1 Year	If Under 24 Hrs. 8 Date of		Baltimore	
	Funeral Director			M 2□F 89 Y	Months Days	Hours Min. 8. Date of (Month) 09/12	71914	Mary	land
	Maryland -f ahow sed at	tor	10a. State 10b. County	10c. City, Town County Towson				10	d. Inside City Limits 1 Yes 2 No
	h with the 3a or 28a at be notifi	Funeral Director	Maryland Baltimore 10e. Street and Number 8413 Loch Raven Bly	_	10f. Zip Code 21286	5		tizen of What Count	y?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itama 23s or 28s-f show other traumatic event, the Marical Experiment can be notified at	p	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hif Yes, specify Cubi	dispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:	No-	14. Race - America Black, White, e Specify: Wh	
215-0036	hin 72 ho s. In "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Decedent's Usual Occup Give kind of work done life. DO NOT use retired	during most of working	16b. K	ind of Business/Inde	ıstry
7	filed withi Hygiene. other than	E O	4		l Estate			Sales	
pu	be filed tal Hygid d other	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Midd	de, Maiden	Sumame)	
<u>ya</u>	should be and Mental marked o	ပ္	William Frank Jarre			Eva Hurlock		,	
Maryland	12 sho		19a. Informant's Name/Relationship (Type Bryan Bishop/P.O.A			and Number or Rural Route Num es St., Suite 5			
	1 and 2 Health am 27 other tra		20a. Method of Disposition		Disposition (Name of	Date	_	ocation - City or Tow	
Baltimore,	permit. Pages Department of h Important: If its any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ R. '4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	crematory or other place Cemetery	04/05/2004		stertown,	
Ball	Departing Depart		21. Signature of Funeral Service License	е	22. Name and Addre Fellows He 130 Speer I	ss of Facility elfenbein & New Koad, Chesterto	nam F wn. M	uneral Ho	me ₂₀ P.Α.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do no	t enter the mode of dyin	g such as cardiac or respiratory	arrest,	1.	Approximate interval Between Onset and Death
E	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	-				
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequence of): 				
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Ic. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		-	23d. Date of delivery Month D	/ Day Year
Records, P.	luires that signed b lid be deta	þ	Part II. Other significant conditions con		he underlying cause giv	111		use contribute to the	cause of death?
00	aw requir is been si 2 should i	lete	pvp	unu		24a. W	as an	24b. Were autons	sy findings available
al Re		Completed				au pe	topsy rformed? 2 No	prior to come death? 1 \(\text{Yes} \) 2	pletion of cause of
Vital	sician: certific rector,	o Be	25. Was case referred to medical examiner?	ospital:	Oth	26. Place of Death (Check only			
of	ding Phys h. After this funeral di	\vdash	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Tin Inju	ne of 28c. Injury	Nursing Home 5 Re			
Division	I or Attendi after death. Director: A I in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location	(Street an Town, State	d Number or Rural i	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Directors After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	cian: To the best of my knowledge, on the basis of examination and/land manner stated.	death occurred at the tin or investigation, in my o	ne, date and place, and due to the pinion, death occurred at the time	e, date and	and manner as stat place, and due to t	ed. ne cause(s)
)	To the within To the comp	M	29b. Signature and title of ceptifier	ins	29c. Licens			signed (Month, Da 3 13) (O	
			30. Name and address of person who con	ndet d cause of death (Item 23a) (Ty	ype, Print)	27569 8 (40000 T	120	Rd	21208

State Registrar

DHMH 17 Rev 1/2001

APR 0.5 2004

Division of Vital Records, P.O. Box 68760.

			_ For	State of M		d / Depa	artme	nt of He	alth and M	•		_	13272
			1 - State Registrar			Ce	rtifica	te of D	eath		Reg. No.		
	Physici /Medic		1. Decedent's Name (First, Middle, Walter Harrison							2. Date of De Month	Day	2004	3. Time of Death 5:10 DM M
	Examir		4a. Facility Name (If not institution,	give street and number)			4b. Cit	y, Town, or L	ocation of Death		4c. Co	unty of Death	
			Washington Coun	ty Hospital				gersto			Wasl	hingto	n
	Funeral Director		214-09-2937	6. Sex 7. Ag 1 🔯 M 2 🗆 F	87 (In yrs. 1	last birthday) Yrs.	Month Month		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/12/	v, Year)	9. Birth	place (State or Foreigr Intry) MD
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation					1	10d. Inside City Limits
	Aaryk Fsho	ō	MD Washi	ngton		erstov							1√2Yes 2 □ No
	28a-	Director	10e. Street and Number		1146	,orboo.		ip Code	·		10g. Citizen	of What Cou	intry?
	3e or	Ö	268 S. Potomac	Street			2	L740			USA		
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Dec	edent of Hisp	panic Origin? (Sp Mexican, Puerto	ecify Yes or No	14.	Race - Amer Black, White	
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Other Zie marked other then "naturel", or Iteme 23e or 28e-f show other treumatic event, Ite Michigal Examinations as the multified at	b	1 ☐ Never Married 2 ☐ Marrie 3 🙀 Widowed 4 ☐ Divorced			1		2⊠ No	Specify:	rticari, etc.)			hite
Maryland 21215-0036	nin 72 ho n natur Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or	5.1)	(Give	kind of v	ual Occupati vork done du use retired)	on ring most of work	ing	16b. Kind	of Business/I	ndustry
217	d with giene grene grene	E O	12	College (1-40)	JT)	Brio	ck L	ayer			Cons	struct	ion
2	al Hy al Hy d othe	Be	17. Father's Name (First, Middle, L					1	8. Mother's Nam			mame)	
<u>X</u>	should the should the should the should the should be sh	0	Samuel Calvin K						Mary El				
	and 2 sh ealth and n 27 ie m		19a. Informant's Name/Relationsh Walter H. King,				•		e, Marti				p Code)
ġ,	ges 1 a t of He if Item or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	2 C Bomoval from State	20b. P	lace of Dispo emetery, crei	osition (A	ame of other place)		Date	20c. Locati	on - City or T	own, State
Ĕ	Pages ment of t ent: If It ury or o		`4 □ Donation 5 □ Other (Sp		Ros	se Hil	.1 Ce	metery	04/1	3/2004	Hager	stown,	MD
Balt	permit. Pages Department of Importent: If It any injury or o		21. Signature of Funeral Service L	icen, e	2				^{of Facility} Geomac Str				neral Home D 21740
ı	Physician //Medical Examiner Physician and	Examiner	23a. Part1. Enter the disease, or a shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, the probability of the cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	only one cause on each li	a consequence	uence of):				от гезрігатоту а	nest,		Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be enter has been signed by the attending physician age 2 should be detached for use as the burit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	2 Fetal	death 3	□Ectopic □ Other (pregnancy specify)			23d.	Date of delive Month	rery Day Year
υ, L	ss that gned b	by Pł	Part II. Other significant condition	s contributing to death b	ut not resu	ulting in the u	nderlying	cause given	in Part I.	23e. Did t	obacco use o	contribute to	the cause of death?
ğ	w require been sig should b	ted								10,	Yes 2.□N	o 3□Pro	bably 4 □Unknown
Vital Records,	The law note that has be age 2 sh	Completed	•									prior to co death?	opsy findings available ompletion of cause of
	sicien: Th certificate rector, pag	BeC	25. Was case referred to medical					_ 2	26. Place of Deat				
	hysic nis ce I direc	10 E	examiner? 1 ☐ Yes 2☐ No	Hospital:	ent 2 🗆	ER/Outpatier		OCA Other:	4 Nursing Ho	me 5 Resid	dence 6 🗆	Other (Speci	fy)
ouo	Attending Physicien: or death. ector: After this certifically the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		y Year)	28b. Time o Injury	f M	28c. Injury a Work? 1 ☐ Ye	s 2 □No	28d. Describe I	now injury oc	curred	
Division of	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could n 4 Homicide determine				reet, fact	ory, office		28f. Location () City or To	Street and Ni vn, State)	umber or Rui	al Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	f examinat	wledge, deat tion and/or in	h occurre vestigation	d at the time, on, in my opin	, date and place, nion, death occurr	and due to the ed at the time,	cause(s) and date and pla	manner as a	stated. to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	0.04			2	9c. License r	number		29d. Date sig	gned (Month,	Day, Year)
			1+a0	letro	MA	7		053	273		April	11 20	104
LY	1241	1	30. Name an 27 ress of person v	no completed cause of c	leath (Item	23a) (Type,	Print)	/.	000	1 1	1	t	1 2 8 2
2	C.	10	31. Date filed (Month Par) Year)	2 32. Be gistr	ar's Signa	ture JC	per	lon G	Hord A	mthop	mg,	Md o	2118-3
	Sta Registi		Ark I's	2004 Lines	ر سد	1. A.	raide						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	larylan	d / Depa <i>Cei</i>	artmen rtificate	t of H e <i>of L</i>	ealth a Death	and M		jiene 1eg. No.	200	4	13273
			1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea Month	th Day	Yea		3. Time of Death
	Physici /Medio		Shirley Jean Kell	.er							A Dru	Ole	-		M 540
	Examir		4a. Facility Name (If not institution, give	street and number	7)		4b. City,	Town, or	Location of	f Death			County of D		
			Washington County	Mospital	L			erst				Wa	shing	ton	
	Funeral		5. Social Security Number 6. S	ex 7. A □M 2⊠F		ast birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day	, Year)	9. 8	Birthpla Country	ce (State or Foreign
Ľ.	Director		220-20-7755		70	Yrs.					07/26/1	<u>.933</u>			MD
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					-		100	d. Inside City Limits
	Manyl f sho	ō	MD Washingt	on	Has	gerstov	vm								1⊠Yes 2 No
	1he 288-	rect	10e. Street and Number			,0_0_0	10f. Zip	Code				l0g. Citiz	zen of What	Countr	v?
	3a or	0	53 Devonshire Roa	$^{\mathrm{id}}$			21	740				USA			
	death ms 2	by Funeral Director	11. Marital Status	12. Was Deceden		S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	1	14. Race - A		
9	after or Ite	Ī	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give			1 ☐ Yes :		Specify:	, rueno r	nican, etc./		Black, W	white, et Whit	
93	ours rral',		3 ☐ Widowed 4 Noivorced	Year or Dates	:-		10 165	2 24 140	эрөспу.				Specify:	M11T (-e
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f show he Medical Exerciper roughter recipited at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de co <i>mpleted)</i>		16a. Deced (Give	kind of wor	rk done a	lurina mosi	of workir	ig	16b. Kir	nd of Busine	ss/indu	stry
121	within ane then	m du	Elementary/Secondary (0-12)	College (1-4or	5+)		istere						Healt1	haar	20
2	filed v Hygie ther i	ပိ	17. Father's Name (First, Middle, Last)			re.	rarere	eu M		r's Name	(First, Middle,			licai	.е
an	d be antal red o	o Be	Charles Lester Di								Grace Po				
Maryland	2 should be filed within ? n and Mental Hygiene. I's marked other then "r reumatic event, I're Med	ပ	19a. Informant's Name/Relationship (19b. Mailir	ng Address	(Street a			Route Number		Town, State	a, Zip C	ode)
	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, If a Madical Exacting remains the rotified at		Joanna L. Rideout	. / Daught	ter	4 Kei	rv Co	ourt	. Bal	1sto	n Spa,	NY 1	2020		
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent; If item 27 Is eny injury or other tre once.		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of					cation - City	or Tow	n, State
Ë	Pages nent of I ant: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		Pa I	lar Lav			· 1	4/08	/2004	Hage	rstow	n, N	10
alti	permit. Departm Importe eny inju		21. Signature of Funeral Service Licer	500	>										eral Home
m	Deparenti Impor		Son y		_	3(05 N.	Pot	omac	Stree	et, Hage	erst	.own, i	MD 2	21740
	F.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death line.	. Do not ent	er the mod	e of dying	g, such as	cardiac o	respiratory arr	est,		- 1	opproximate nterval Between
	Physician		Immediate Cause (Final disease or condition	OVA	1211	201	Cato	1ce	10					C	Inset and Death
	/Medical		resulting in death)	Due to (or a	s a consequ	uence of):	7.15								
В	Examiner		Sequentially list conditions,	b											
	pg tis	Examiner	if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	Due to (or a	s a consequ	ience of):								1	
	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ience of):									
8760,	death certificate be executed e attending physician and id for use as the burial-transit	a E		040 10 (01 4	3 ta 001130q0	201100 017.									
687	cate phys the	dical		d											
	certif Iding	//We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna	ncy						2	3d. Date of	deliverv	
Вох	leath atter	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pro Other (sp.						Month	,	ay Year
O.	the d y the ached	ysi	1 □ Yes 2 MNo 9 □ Unknown	9□ Unknown				-							
σ,	n requires that the death certific been signed by the attending p should be detached for use as i	by Physician/Med	Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tol	bacco us	se contribute	to the	cause of death?
Records,	quire	ed b					<u> </u>				1 □ Ye	es 2	□ No 3 □	Probab	y 4 Unknown
00	law renas bee	Completed									24a. Was a		24b. Were	autops	y findings available
Re	9 L B	E									autops perform		prior t death 1 🗆 Y	?	iletion of cause of
Vital	i clen : Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	(Check only on		101	03 2	4,10
\	di Si	To B	examiner? 1 Yes 2 X	Hospital: 1 Inpai	tient 2 🗆	ER/Outpatier	it 3 DO	A Othe	ar: 4 □ Nu	rsing Hon	ne 5 ☐ Reside	ence 6	Other (S)	pecify)	
n of		ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Pay Year)	28b. Time of Injury	2	8c. Injury Work	at	2	8d. Describe ho	ow injury	occurred		
Ö	Attending r death. ector: After by the fune	atle	2 Accident investigation				М		/es 2□i	No					
Division	or Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined	288. Place of I	njury - At ho etc. (Specify	me, farm, str	eet, factory	, office		2	8f. Location (St City or Town		d Number or	Rural F	Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the		A/1				22-21					- 17.		cans	
	Hospital 24 hours a Funeral tely filled	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the bes niner: On the basis	of examinat	wledge, death tion and/or in	occurred vestigation,	at the tim , in my op	e, date and inion, deal	d place, a th occurre	nd due to the card at the time, d	ause(s) : ate and	and manner place, and d	as state lue to th	ed. ne cause(s)
	To the within 2 To the complet	Med	29b. Signature and title a sentiner	and manner s	stated.		290	. License	number		2	9d. Date	signed (Mo	onth. Da	v Year)
	F 3 F 8		1	9//			n			/		1/	1.1	u	, /
	4	1	30. Name and address of person who	completed cause of	death (Itam	23a) /Tune	Print)	د کات	577	L	:	12	104	1	1. 0
V	34		//SA /// W DA/RAT			01 CAC	CA	12,15	5177 Dr	FN	3	eice	572441	7 /	72
6	Sta	ate	31. Date filed (Month, Day, Year)		trar's Signal			00	21-		J				
			APR U 7 /	114 /	/	7. 450	arted								

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of I	lealth and M <i>Death</i>		giene2 () (Reg. No.	04 13274
	Physici		Decedent's Name (First, Middle, Last) Frances Lorra					2. Date of De Month March	Day	Year 1110 AM
P	/Medio Examir		4a. Facility Name (If not institution, give s Washington County	street and number)	L	4b. City, Town, or Hagerst	r Location of Death	March	4c. County o	of Death
	Funeral Director		5. Social Security Number 210-30-2340 6. Sex		(In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da May 22,	h	Birthplace (State or Foreign Country)
	Maryland -f show	tor	Usual Residence of Decedent	-on	10c. City, Town or Lo					10d. Inside City Limits 1 XYes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show	ai Director	10e. Street and Number 65 Westside Ave		nagerstov	10f. Zip Code 2174	0		10g. Citizen of WI	The state of the s
36	urs after dea II', or Items	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🕱 No	ispanic Origin? (Spi n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		- American Indian, , White, etc. White
Maryland 21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or Items 23s or 28a-f show event, the Medical Examainer must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occupa kind of work done of DO NOT use retired,	furing most of work	ing	16b. Kind of Bus	
and 21		To Be Cor	8 17. Father's Name (First, Middle, Last) Edward S. Marti	.n	Homen	naker	18. Mother's Name		own ho Maiden Sumame, ia Dick	
	12 sh h and 7 Is m treum	1	19a. Informant's Name/Relationship (Type Tracy L. Dayhoff			g Address (Street a	and Number or Rura	al Route Numbe	r, City or Town, Si	tate, Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Important: if Item 27 any injury or other tre		20a. Method of Disposition 1 \(\begin{align*} \begin{align*} 1 & \begin{align*} 2 & \begin{align*}		20b. Place of Disposementery, crem	sition (Name of natory or other place	9)	2004		ity or Town, State
Balt	permit. Departrimonts Imports any inji		11 30	men	5	Name and Addres S Broad	s of FacilityGrov IST Wayne	ve-Bowei esboro,	csox Fune PA 17268	eral Home, Inc.
	Physician /Medical		23a. Paid. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Pne	umonio		g, such as cardiac c	r respiratory ar	rest,	Approximate Interval Between Onset and Death
H	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ren	consequence of):	iture				
68/60,	icate be executed physician and s the burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last		nsequence of):	Heart	Faile	~ V *		
C. Box ba	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{tys.} 2 \subseteq \text{No} \) 9 \(\subseteq \subseteq \text{Unknown} \)	ac. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 9 □ Unknown	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
ecords, P.	requires that the een signed by th hould be detache	by	Part II. Other significant conditions conf	ributing to death but	t not resulting in the un	derlying cause give	n in Part I.			ute to the cause of death?
r	The la ate has page 2	Completed						24a. Was a autops perform	med? pric	ore autopsy findings available or to completion of cause of ath?
ION OF VIE	To the Hospitel or Attending Physician: which 24 hours after death. To the Funaral Director: After this certification in the funeral director, completely filled in by the funeral director.	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatien 28a. Date of Injury (Month, Day	28b. Time of	3 DOA Other	4 Nursing Hon	ne 5 Reside	ne) ence 6 □Other ow injury occurred	
DIVISION	itel or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, office	2	8f. Location (Si City or Town	reet and Number 7, State)	or Rural Route Number,
	thin 24 hours thin 24 hours the Funa mpletely fi	Medical	one)	cian: To the best of er: On the basis of e and manner state	my knowledge, death examination and/or invested.	estigation, in my opi	inion, death occurre	d at the time, d	ate and place, and	d due to the cause(s)
	\ \ \ \		29b. Signature and title of certifier Territory 20. Name and address of passes who are	when	ab (lee = 00) ==		6039E	2	9d. Date signed (A	Month, Day, Year)
JA.	Sta		30. Name and address of person who con	SHED	's Signature	6 Opal	Court	Hey	MJ. 2	1742
	Registra	ar	MAR 12 200	32. Registrar	J. Sp	uli)				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey Year 2:16 PM Hwa Jung Kang Apri] 10 2004 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Hillside House Clarksville Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Date of Birth (Month, Day, Yeer, Birthplece (State or Foreign Country) Days Months Hours 1□ M 2√ F 212 57 8987 81 Apr 8, 1923 South Korea Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Howard Ellicott City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10306 Boca Raton Drive 21042 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 DWidowed 4 □ Divorced Year or Dates Asian 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) None None 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Icsev Kanq Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 10306 Boca Raton Drive Ellicott City, MD 21042 Yoon Jung Kim/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4-12-2004 Catchsville, MD M01044 21. Signature of Funeral Service Licenses Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of). Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ni V Due to (or as e consequence of) Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? ZIZNO 1 Ves 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 2010 1 Tes 2 ER/Outpatient 3□ DOA 6 Denner (Specify) asst. lvg. 27 Menn of Death Natural 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation

Examiner Examir ettending physiclen and for use as the bunal-transit law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760 Physician/Medical ed by the e been signed by þ ይ Completed page 2 should Be ٩ Certification:

Physician

/Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

permit. Peges 1 and 2 should be filled within 72 hours efter death with the Marylend Department of Health and Mental Hygiene.
Important: If item 27 ie marked other than "nature!", or items 23s or 28s-f show any injury or other treumatic event, to Medical Examinat must be notified at once.

altimore. Marvland 21215-0036

Mospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice funerel I Director: A ፩ To the Hosp within 24 ho To the Fune

Medical 29b. Signature and title of certifier Dr. Yoon Jung Kim 10306 Boca Raton Drive Ellicott City, MD 21042

6 Could not be determined

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29c. License number

2 No

1 Ti Yes

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

April 10, 2004

30. Name en 1 ddress of person who completed cause of deeth (It an 23e) (Type, Print)

31. Date filed (Month, Day, Year) APR 13 2004

egistrer's Signeture 32

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

Registrar

002

			1 - For Stete Registrar	State of M	arylan	d / Depa	artmen rtificat	t of H e of L	ealth a Death	ind M		giene	/	. 13	3276
4	Physici /Medi		1. Decedent's Name (First, Middle, La	LEVEY							2. Date of De Month	nath Day	2 Z.009	/ "	32AM
	Examir		4a. Facility Name (If not institution, give November 174 or Mi	APYLAND M	Wou		em	Sm	Location of	26			County of Dee		
(t.	Funeral Director		5. Social Security Number 6. S 217–32–6883 Usual Residence of Decedent	M 2□F		last birthday) 66 Yrs.	If Under Months	Days	Hours	Min.	8. Date of Bir (Month, De Jan. 9	y, Year)		thplace (Stai buntry) yland	te or Foreign
	Maryland -f ehow	tor	10a. State 10b. County Maryland Washing	ton		y, Town or Lo									City Limits
	with the a or 28a	Direc	10e. Street and Number 250 Potomac heigh				10f. Zip	Code 1742				10g. Cit	izen of What Co	ountry?	
036	77 hours after death with the Maryland "neturel", or items 23a or 28a-f show valical Extra ultraft be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 If If Yes, Give Year or Dates:		4		dent of His	spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No Rican, etc.)	-	U.S.A. 14. Race - Ame Black, Whit		,
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Maryland 2	d be filed ental Hygi ked other c event, I	To Be Co	12 17. Father's Name (First, Middle, Last, Harold Levey)		Nut	triti		18. Mother		(First, Middle,	Maiden	VNer Sumame)		
	nd 2 shoul		19a. Informant's Name/Relationship (Colleen I. Leve	**.									r Town, State, . Marylai		42
Baltimore,	permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tru		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		0	Place of Dispo emetery, cren St Have	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Lo	cation - City or Jerstowi	Town, State	
Balti	permit. Departm Importal any inju		21. Signature Funeral Service Licer		Zin	22	. Name an	d Address	s of Facility	Do	uglas A	. Fi	ery Fur	neral	Home
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ion of	fing Ph After th funeral	atlon: To	27. Menner of Death 12 Naturel 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry	28b. Time of Injury	_	Bc. Injury Work	4 🗀 19015	2	1e 5 ∐ Resid 8d. Describe h		Other (Special occurred)	cify)	
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		Me	29b. Signature and little of certified	Canar	mj			License Do		598			signed (Month		
10	1241		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type, I	Print)	X-P	I AM	ו פמה	Nearm	5-	son i	lan.	mo
Í	Sta Registr	1.	31 Date filed (Months Dave Year)	2004 32. Registra	ar's Signa	ture.	serle	,					,	20077	

			For State Registrer		State of N	iaryland / l	Cer	artment of F rtificate of	ieaith Death	and Mer		leg. No.	04	132	77
	Physici /Medic		1. Decedent's Name (First, Mic		MARIE	LEUS	CHN	ER			Date of Dea Month APRIL	Day 2004	Year	3. Time of D	
	Examir		4a. Facility Name (If not institut 2007 Vienna)		4b. City, Town, o	r Location	of Death		4c. County			
Ī	Funeral Director		5. Social Security Number 218–22–3644	Road 6. Sex		ge (In yrs. last bii 74	rthday) Yrs.	Vienna If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day ay 4,1	Year)		er lace (State or l try) Vland	Foreign
	and and		Usual Residence of Decedent 10a. State 10b. Cour	ity		10c. City, Tow	n or Lo	cation					1	0d. Inside City	/ Limits
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	or 288	Director	10e. Street and Number					10f. Zip Code				10g. Citizen of	What Cour	try?	
	s 23a	ral	11771 Shar			A Event in U.C.	10.1		837	isis2/Caseth	. Van ar Na	USA	e - Americ	an Indian	
336	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortant: If Itam 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Event artimatic budfiled at injury or other traumatic event, the Medical Event artimatic budfiled at 8.	by Funeral	11. Marital Status 1 □ Never Married 2X M 3 □ Widowed 4 □ Divorce	arried	 Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates: 	?]No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No			an, etc.)	Specif	ck, White,		
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121	within ene.	mple	Elementary/Secondary (0-12		College (1-4or	5+)	life.	kind of work done DO NOT use retired	d)			Far	mina	Poultr	3.7
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Division of Vital Records,	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	3 Suicide 6 □ Cou	ding estigation Id not be ermined	(Month, D 28e. Place of In building, 6		Injury arm, str	M 1 □	k? Yes 2 ∐	-	Location (S. City or Town	treet and Numb n, State)	er or Rura	l Route Numbe	∂ <i>r</i> ,
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7	-hard		30. Name and address of pers	on yno con	npleted cause of	0 111	_	Print)	Paral	and a	70	(nli)	6.10	m T 4	1001
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			WiCHD, dq Amend#10e,19b,PerFH		•	•	rtment of F		Mental Hyو ا	giene Reg. No. 2004	13278
			Decedent's Neme (First, Middle, Lest)	,04-10-	U4				2. Date of Dea		3. Time of Death
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	Examin	er	4a Facility Name (If not institution, give str	-			- 4		or Locetion of Death	,	
			5772 Cork Stree				If Under 1 Year	Sali If Under 24 F	sbury	Wicomic	
	Funeral Director	- 1	5. Social Security Number 6. Sex 120 6. Sex	1 2□ F 7. A9	90 (In yrs. 12 73	ast birthday) _ Yrs.	Months Days		Irs. 8. Date of Birtl in. (Month, Day Sept. 1	v, Year) Co	hplace (State or Foreign untry)
	The A		Usual Residence of Decedent		73				sept.1	1930 N.C	arorria
	urylen show		10a. State 10b. County		10c. City	, Town or Loc	ation				10d. Inside City Limits
	Ba-f s	20	Maryland Wicomi			Salis					1 ☐ Yes 2. No
	with th	듑	10e. Street end Number 1605 Waco	nia Dri	ve		10f. Zip Code			10g. Citizen of What Co	untry?
	eath	era	6105 Waconia Dr.	Was Decedent	Ever in U.S	S. 13. W	218 ((Specify Yes or No-	U.S.A 14. Race - Ame	rican Indian.
Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene. Important: if flem 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral Director	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X yes 2 If Yes, Give Year or Dates:	No	lf 1	Yes, specify Cuba □ Yes 2 ※ No	ın, Mexican, Pu	èrio Rican, etc.)	Black, White	
Ö 2	72 hor	Be Completed by	15. Decedent's Educa	tion	, , ,	16a Decede	ent's Usual Occup	ation	working	16b. Kind of Business/	
21	ithin 7	npie	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or	5+)		ind of work done on NOT use retired	duning most of (VOIKING		
7	led w lygien her th	ပ္ပံ	7			Lab	orer	40.84-4-1-1-8	1	None	
and	d be find th	Be	17. Father's Name (First, Middle, Lest)						lame (First, Middle,	· · · · · · · · · · · · · · · · · · ·	
<u> </u>	should and Men merke umeric	၉	Jim Leak 19a. Informant's Name/Relationship (Type	. Print)		19b. Mailing	Address (Street		ie Crowd		ip Code)
	end 2 saith er a 27 is	1	Margaret Leak (W			1605	Waconia	Drive	alisburv	r, City or Town, State, 2	,, , , , , , , , , , , , , , , , , , , ,
altimore,	es 1 e of Hez	100	20a. Method of Disposition	-	20b. Pla	ace of Dispos	ition (Name of atory or other place		Date	20c. Location - City or	Town, State
<u>E</u>	Peges nent of int: if its iry or o		1 ■Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State	-		an Ceme	•	4.16.04	Hurlock,	Md.
3alt	permit. Peg Department Important: i any Injury o		21. Signature of Funeral Service Licensee	0		\$22. \$1	Name and Address	s of Facility			
œ	205 2	1	Bladys B.	Stew	art	82				Md.21801	
	Physician /Medical Examiner	Jer	23a. Part1. Enter the disease, or complications, or heart fadure. List only one Immediate Cause (Final disease or condition resulting in death) a	mala	sta	as a consequ	Lum		rcer	 	Approximate Interval Between Onset and Death Months Approximate
Box 68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician and pege 2 should be deteched for use es the burlel-transit	edica	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in death) Last			as a consequ					
ğ	death e ette ed for	Sicia	Part II. Other algnificant conditions contri	outing to death b	ut not resul	ting in the und	derlying cause give	en in Part I.	23b. Did to	obacco usa contributa	to the cause of death?
, P.O	that the ned by th deteche	Phys					, , ,		y y	as 2 No 3 Pr	obably 4 Unknown
Records,	e law requires that the death certific hes been signed by the ettending r ge 2 should be deteched for use es	Completed by							24a. Wes a perform	med? a	Vere autopsy findings vailable prior to ompletion of cause f death?
	The sete h	5							+U+	35 25 No 1	□Yes 2□No
Vital	iclan: The certificate rector, peç	Be	25. Was case referred to medical examiner?	pital:			Oth		eath (Check only or		
0	Physical directions of the direction of	<u>۹</u>	TE TES ALE NO	^{phan} 1 ☐ Inpatie 28a. Date of Inju	-	R/Outpatient 28b. Time of	3□ DOA Oth	4 LI Nursing	-	nd Home ence 6 Other (Spec ow injury occurred	ify)
o	ding th. After	盲	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, De	y Year)	Injury	28c. Injun World M 1 🗆	k? Yes 2 □ No	200. 2000100 11	on injury occurred	
Division	To the Hospital or Attending Physician: The is within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, pege	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et			et, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, Stete)	ral Route Number,
	To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in by	edicai	29a. Certifier 1 ✓ Certifying Physic (Check only one)	an: To the best of On the basis of and manner sta	examination	ledge, death on end/or inve	occurred at the timestigation, in my op	e, date and pla pinion, death of	ce, and due to the courred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	within To the		29b. Signature and title of certilier	1	111		29c. License	number	2	9d. Date signed (Month	, Day, Year)
		9	NULL	4	WU)		DA	627	8	4-12-	04
11	A a		30. Name and address of person who com	pleted cause of d	leath (Item :	23e) (Type, P	rint)	Salis	2 . M	D 21801	
	Stat Registra	E	31. Date filed (MontA Par Year) 2 200	4 32. Registr	ar's Signatu	ire &	Spars	2	0		
				1			1 1 000				

State of Maryland / Department of Health and Mental Hygiena Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4 2004 3:45 A M **Physician** JAMES JOSEPH LEAHY, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anchorage Nursing and Rehabilitation Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex ★ M 2 F **Funeral** Months PA 85 9/1/1918 165-18-1569 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County ms 23s or 28s-f show 1 Yes 2 No Ocean Pines Worcester MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21811 8 Pelican Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ X/es 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Iten any Injury or other traumetic event, the Medical Examiner since. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cryptanalyst U.S. Government 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Casey Raymond J. Leahy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 19a. Informant's Name/Relationship (Type, Print) 11021 Old Princess Anne RD Princess Anne, MD James Leahy, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of the Pines 4/16/04 Ocean Pines, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility he Burbage Funeral Home 21. Signature of Funeral Service Licensee acqueline 108 William St. Berlin, MD 27a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WARD NARY ARTERY DISTASE Physician YUNK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2**X** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident safter death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled 24 hours a 1 🗙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 14/5 2004 DO51359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Usha Natesan 1415 S. Division St. Salisbury, MD 21804 31. Date filed (Month, Day, Year) Megistrar's Signature State APR 14 2004 Registrar

DHMH 17 Rev 1/2001

RKD CAITLIN E. LUTZ State of Maryland / Department of Health and Mental Hygiene O () (Unpend Item#23a, Part II,27,28a-f, Per Me 33.0,4728/1/99). 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** CAITLIN ELIZABETH LUTZ APRII 17, 2004 2:05P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBRON

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Rt.50 E/B Old Railroad Road WICOMICO 8. Date of Birth (Month, Day, Year) 04-29-1991 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 💢 F SALISBURY, MD. Yrs. Director 212-33-6354 12 Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 🏖 ☐ No WICOMICO SALISBURY MD ₽ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a 21804 USA 30685 HEATHER GLEN DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: \$ Specify: 3 Widowed 4 Divorced WHITE "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.
7 Ie marked other then " Elementary/Secondary (0-12) College (1-4or 5+) STUDENT STUDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES LEROY LUTZ KAYE CARRIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 le
any injury or other trau JAMES LEROY LUTZ - FATHER 30685 HEATHER GLEN DRIVE, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 Donation 5 Dother (Specify) SUNSET MEMORIAL PARK 04-23-2004 BERLIN, MARYLAND 21. Signature of Funeral Service Licens 22 Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Head Injury /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Thermal Injury and Stroke Inhalation 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s deathir 1 XYes 1X Yes 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 XOther (SpecifyCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Y Yes 2 □ No ۲ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending investigation multi-vehicle collision death. 4/17/04 1 ☐ Yes 2 X No 2 Accident in by the Director 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Troadway

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, who country and all the time, date and place, and due to the cause(s) and manner stated. the Hospital within 24 hours a 29a. Certifier Medical (Check only one) ace, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. APRIL 18,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. Greenberr 111 Penn Street, Baltimore, Maryland 21201 asha 32. Registrar's Signature 31. Date filed (Month. Day State Registrar

Please Type of Print in Black indelible link. Elistic All	Copies Are Legible.	
State of Maryland / Department of Health and M 1- State Unpend Item#23a,27,28a-f, Per MF,C830,6674 Case of Death	lental Hygiene 00 L	13

C.	LUTZ		1 - Stete Unpend Item#23a	State of I ,27,28a-f,	Marylan Per ME,	id / Depa G830,44	artmen Wal	tofH <i>e of L</i>	ealth ar D <i>eath</i>	nd Me		gienez	004	1328	8 1
			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ath Day	Voor	3. Time of De	eath
	Physici /Medio		KAYE CARRIER LUTZ							12	APRIL	17,	, 2004	2:05P.	М
	Examir	100	4a. Facility Name (If not institution, giv	e street and numb	er)		4b. City,	Town, or	Location of	Death			ounty of Death	1	
			Rt.50 E/B Old Rai					BRON					COMICO		
	Funeral Director		213-90-9004	ex 7. □M 2∏ F	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under 24 Hours	Min.	8. Date of Birth (Month, Day 03-20-1	, _{Year)} 1966		place (State or F intry) ISBURY, M	
	aryland show		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City I	
	the Ma	Director	MD WICO	MICO	SA	LISBUR	Y 10f. Zip	Code				10g. Citize	n of What Cou	1 Tes 2	X NO
	3a or	<u> </u>	30685 HEATHER GLE	N DRIVE				2180	1/4			54 1104	USA		
	ms 2;	Funeral	11. Marital Status	12. Was Decede		.S. 13.	Was Deced			n? (Spec	cify Yes or No-	14.	Race - Amer		
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b	othe vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	s Name	(First, Middle,	Maiden Su	ımame)		
/lar	uld by Menta urked	To E	WILLIAM CARRIER						MYRNA	BAK	ER				
Maryland	2 sho and I s me		19a. Informant's Name/Relationship (19b. Mailir	ng Address	(Street a	and Number	or Rural	Route Numbe	r, City or T	own, State, Z	ip Code)	
	and lealth m 27 her tr	Ш	JAMES LEROY LUTZ	SPOUSE	205 5	30685			GLEN I		E,SALIS		MARYLA	AND 2180	4
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Baltimore,	t. Pa ntmen rtent:		* 4 ☐ Donation 5 ☐ Other (Special Service Lice)		SU	NSET M			ARK 02				IN, MAF		
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68760,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or	as a conseq	uence of):									
O. Box	The law requires that the death certifica ate has been signed by the attending progge 2 should be detached for use as it	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ★ Unknown		n 2 🗍 Feta It at time of d	ıl death 3 [Ectopic pr					230	d. Date of delive	very Day Yea	ar
ds, P	uires that signed b Id be deta	by	Part II. Other significant conditions	contributing to deat	th but not res	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	_		the cause of deal	
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Division	or Attending ifter death. Director: Afte in by the fune	Certification:	2 Xaccident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of building	Injury - At h , etc. (Specif	ome, farm, str				2	8f. Location (S City or Tow	itreet and M	Number or Rui	ral Route Number	r,
۵	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medicel Exe	nysician: To the beminer: On the bas and manne	est of my kno	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date and pinion, death	place A	icanico (County	, Maryla	oad Rd., stated. to the cause(s)	
	To the within To the Somple	Me	29b. Signature and title of certifier				290	c. License	number		2	29d. Date s	signed (Month	, Day, Year)	
	1		Jasher?	Treen	sey	nep		0.	C.M.E.	•	A	PRIL	18,200)4	

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tasha Z Greenberg M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, APR 2 2 2004) 32. Register's Signature

Aparks Sporks

DHMH 17 Rev 1/2001

			For State Registrar		State of N	Marylan	d / Depa	artmen rtificat	t of H e <i>of L</i>	ealth a	and M		Reg. No.	200) 4		282
	Physici	an		e (First, Middle, Las		mtt						2. Date of De Month	ath Day 7	200	ear	3. Time of	
	/Medic	cal	RONALI	E • I	INDENMU			4h Cîtv	Town or	Location of	of Death	April		County of		12:5	юр
	Examir	ier		Hospital		•• /		,.	ktor					Cecil			
	Funeral		5. Social Security N	Number 6. S	ex 7. /		last birthday)		1 Year Days		24 Hrs. Min.	8. Date of Bir	th	9.	. Birthpl	ace (State o	_
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	and *		Usual Residence o	f Decedent 10b. County		10c. City	y, Town or Lo	ocation							10	d. Inside Ci	ty Limits
	Manyli f sho	ō	PA	Delawa	re	Ri	dley	Parl	ζ.							1 🗌 Yes	2 ∑ No
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Z	s should be filed within and Mental Hygiene. Is marked other then aumatic event, the Ma	10		ter Lind			10h Maili	na Address	/Street s			y Broa		Town Sta	ate Zin	Code)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I then 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examplant manual event, the Medical Examplant manual event, the Medical Examplant manual event, the Medical Examplant manual event, the Medical Examplant manual event, the Medical Examplant manual event, the Medical Examplant manual events.			Lindenmı		ife)	F	Stu				idley					2
	os 1 an of Heal item 2 other	LI	20a. Method of Dis		ACII (W.		lace of Dispo emetery, cre					Date		cation - Cit			<u> </u>
JOE	ages ent of nt: If i			KI Cremation 3 ☐ 5 ☐ Other (Specification)							4/1	3/04	We	st C	hes	ter,	PA.
Baltimore,	permit. Page Department o Important: If any injury or once.			unerat Service € cer								Home c					
Ö	E E E E		大			M005		18 W	est	Cro	33	St. Ga	len	a, M	Ď.	21635	5
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.O. Box 68760,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was deceder in the past 12 1	nt pregnant 2 months?	d	2 □ Feta t at time of d	incy	⊒Ectopic pi ⊒ Other (sp						3d. Date o Month		,	fear .
Δ.	s that the ned by e detac	by Ph	Part II. Other sign	ificant conditions of	contributing to death	h but not res	ulting in the u	ınderlying c	ause give	en in Part I		23e. Did 1	obacco u	se contribu	ite to the	e cause of d	leath?
rds	w requires been signi should be											1 🗆	Yes 2	No 3[_ Proba	ıbly 4 □l	Jnknown
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œ —	ate pag	E O										perfo 1 ☐ Yes	ormed? 2 No	dea 1 🗆	th? Yes :	2 No	
/ita	sicien: 1 certifical rector, p	Be	25. Was case refe examiner?	erred to medical	Hospital:		_		100		of Deat	h (Check only	one)				
of \	shys this	2	1 ☐ Yes 2 €		1 ☐ Inpa		ER/Outpatie 28b. Time of		-	4 🗆 NU		me 5 Resi 28d. Describe			Specify,)	
ou	ding After fune	tion	1 ☑ Natural 2 ☐ Accident	5 Pending investigation	(Month, i	Day Year)	Injury	м	28c. Injury World 1 🔲 '	<br Yes 2□				, , , , , , , , , , , , , , , , , , , ,			
Division of Vital Records,	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 4 Homicide	6 Could not b determined	e 28e. Place of	Injury - At he etc. (Specif	ome, farm, st y)	reet, factor	y, office			28f. Location (City or To	Street an wn, State	d Number (or Rural	Route Num	ber,
	Hospitel 24 hours Funerel I etely filled	edical C	29a. Certifier (Check only one)	1 ☐ Certifying Pt 2 ☐ Medical Exam	nysician: To the be miner: On the basis and manner	s of examina	wledge, deat	th occurred evestigation	at the tim	ne, date an pinion, dea	nd place, ith occur	and due to the red at the time,	cause(s) date and	and manne place, and	er as sta I due to	ated. the cause(s	·)
	To the within 2 To the comple	Me	29b. Signature and	d title of certifier				290	c. License	e number			29d. Dat	e signed (A	Month, E	Day, Year)	
			1	_	n D			و	005	9640	2		41	7/2	00 4	/	
			30. Name and add	tress of person who	completed cause of	of death (Item	n 23a) (Type 10G			Street		EIK	ten	mo	7	192	-1
	St	ate	31. Date filed (Mo			istar s Signa		1	(34)			•					

			1 State Registrar	tate of Maryland / De	partment of ertificate or			ene () () 4	1328	3
ı	Physici		Decedent's Name (First, Middle, Last) Charles Ellswort	h Miller			2. Date of Death Month April	Day	Year 004	3. Time of Death	h M
dist	/Medio Examir		4a. Facility Name (If not institution, give street		4b. City. Town.	, or Location of Death		4c. County		0:50	
	LXuiiii	101	Beverly Healthcar			agerstown		15. 552,		nington	
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	y) If Under 1 Yea	If Under 24 Hrs.	8. Date of Birth	Vanel		ace (State or Fore	aign
	Director		Usual Residence of Decedent	2□ F 83 Yrs	Months Days	s Hours Min.	8. Date of Birth (Month, Day, Feb. 9, 19	21	Mar	y land	
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Itams 23s or 28s-f show event. I'm Medical Ever in or must be notified at	_	10a. State 10b. County	10c. City, Town or	Location				10	d. Inside City Lim	
	Ba-f s	Director	Maryland Washing	ton W	illiamspo	ort_				1 🛣 Yes 2 🗆	No
	or 2	Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of W	hat Count	ry?	
	ath v	rai	43 E. Potomac St.			21795			USA		
	er de Itami	Funeral		Was Decedent Ever in U.S. 1 Armed Forces?	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America		
36	rs aft	by F		XXYes 2 □ No If Yes, Give Year or Dates: WW	1 □ Yes 🔾 📉 No	o Specify:		Specify:	1.11	• ,	
9200-512	hou	ed	15. Decedent's Education		cedent's Usual Occi	upation	1.1	6b. Kind of Bus		ite	
5	in 72	Completed	(Specify only highest grade co	mpleted) (G	ve kind of work done . DO NOT use retir	upation e during most of work red)	ing '	oo. Kina of Bus	siness/ind	ustry	
212	filed within Hygiene. Ithar than "	шо	Elementary/Secondary (0-12)	Juliaga (1-401 3+)	ner/Opera		i	estaura	ant/R	owling A	111
ğ	Hygi other	Bec	17. Father's Name (First, Middle, Last)		,	7	e (First, Middle, M			Owing /	111
<u>a</u>		To B	Charles Edward Mi	Her		Susan	Elizabet	h Lest	200		
Maryland 21			19a. Informant's Name/Relationship (Type,		iling Address (Stree	at and Number or Run				Code)	
	and 2 ealth a n 27 is		Sam Miller - Son			c St. Will				Q02-1	
e je	ges 1 a it of He if item or othe		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other pl	aca)		Oc. Location - C		21 <u>795</u> m, State	
Baitimore,	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	VALITION STATE	n Mem. Pa	J	15,2004 W	illiome	(2) Y	M==2001 ==	_1
<u>=</u>	permit. Pag Department Important: I eny injury o		21 Signat self Funeral Service License	Or centaw		ress of Facility Funeral Ho	12,2004 W	TITIAMS	shor.1	, Mary Lan	a
n	90 4 9		V MATEUM			runeral no nococheagu		Hiomon		MD 2179	5
			23a. Parts: Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the death. Do not a	nter the mode of dy	ing, such as cardiac	or respiratory arres	t ramst		Approximate	
	Physician		Immediate Cause (Final disease or condition	Attimochrot	7 00 1	dia co	162	A. a		nterval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as a consequence of):	a care	MO - VUS	auen	desier		MINS.	
	Examiner		Sequentially list conditions, b.								
	ם ב	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):							
	acute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last								
Š	e ex		resulting in deathy cast	Due to (or as a consequence of):							
2/60	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dicai	d								
Ď ×	ding page as	iclan/Me	IF FEMALE:					1			
X O D	death c	lan/	in the past 12 months?		□Ectopic pregnand	>y		23d. Date Mont			
j	the a	hysic	1 □ Yes 2 □ No	I□Pregnant at time of death 5 P□Unknown	Other (specify) _			NOTE		ay Year	
7.	The law requires that the site has been signed by thoage 2 should be detache	۵.	Part II. Other significant conditions contribu	iting to death but not regulting in the	underhing squee a	was in Start !	22a Did taha				
ecords,	signe d be	1 by	3	ining to could but not resulting in the	driderly ling cause gr	venin raiti.				cause of death?	_ 1
0	requ	etec					1 162	2 140 3		DIV 4 DIONKHOV	/m
Ď T	has has je 2 s	Completed					24a. Was an autopsy	pri	or to comp	y findings availab	le f
							performe 1 ☐ Yes 2		ath?]Yes 2	□ No	
N 15	Physician: The lav this certificate has al director, page 2 a	Be	25. Was case referred to medical examiner?	tal:	0		(Check only one)	-			
5	Phys this ral di	2	1 163 2140	1 Inpatient 2 ER/Outpati	SIL 3 DOA		me 5 Residence				
5	ding h. Afte fune	틸		Ba. Date of Injury 28b. Time (Month, Day Year) Injury	Wo	ork?	28d. Describe how	injury occurred	1		
VISTOR	Attan deat ctor: y the	Certification:	3 Suicide 6 Could not be 25	Be. Place of Injury - At home, farm,		Yes 2 No	29f Location (Street	and manufactures to a se	a. 0		_
2	after Dire	erti	4 Homicide determined	building, etc. (Specify)	treet, ractory, onice	1	28f. Location (Stree City or Town, S	State)	or Hural F	foute Number,	
	spita lours neral fillec		29a. Certifier 1 Certifying Physician	n: To the best of my knowledge, de	th occurred at the ti	ime date and place of	and due to the serve				
	To the Hospital or Attanding Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	2 medical Examiner:	On the basis of examination and/or and manner stated.	nvestigation, in my	opinion, death occurre	ed at the time, date	and place, an	d due to th	ed. ne cause(s)	
	Vithin Fo th	Me	29b. Signature and title of certifier		29c. Licens	se number	29d	Date signed (Month, Da	v. Year)	
			Maniera 9.	Scar	7	28761					
	541		30. Name and address of person who comple	ited cause of death (Item 23a) (Typi	. Print)	7 - 3		7-12	-04		
54	-541		MANZAR)	- 11	s mil	28365 U Strail	- Nago	ot au	10/	ארו כ ר	
F	Stat	e	31. Date filed (Month Pay Year) 2 2004	32. Registrar's Signature	1 1		- 030	- Touch		J 61170	\dashv
	Registra	ar	NI IV 1 3 2004	Marcus D. A	parel						

			1 - For State Registrar	State of N		epartment of F Dertificate of			200	4 13284
_	Phys /Me	ician dical	1. Decedent's Name (First, Middle, Las Evelyn Louise Mc	•				2. Date of Death Month April	Day Ye.	ar 3. Time of Death
		niner	4a. Facility Name (If not institution, give Washington Count	y Hospita		Hager			4c. County of D Washi	eath ngton
	Funer Directe		5. Social Security Number 6. S 216-22-0072 Usuel Residence of Decedent	9X 7. A □ M 2 X F	Age (In yrs. last birtho 79 Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Jan. 25,	⁹ 1925 1	Birthplace (State or Foreign Country) Maryland
	Maryland I-f show	tor	10a. State 10b. County Maryland Montgo	mery	10c. City, Town of	r Location antown				10d. Inside City Limits 11 Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show I must be notified at	Funeral Director	10e. Street and Number 3 Willow Spring	Court		10f. Zip Code	20874	10g	. Citizen of What	Country?
	9 2 2	b	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 2 If Yes, Give Year or Dates		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. white
	Maryland 21215-0036 nd 2 should be filed within 72 hours att illh and Mantai Hygliand. 27 le marked other then "naturel; or traumatic event, the Medical Evans traumatic event, the Medical Evans	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		r 5+)	ecedent's Usual Occup Bive kind of work done fe. DO NOT use retired ursing ass:	during most of work d)	ing	b. Kind of Busine	ethodist home
	Baltimore, Maryland 2121. permit. Pages 1 and 2 should be filed within Department of Health and Mantal tyglene. Important: If item 27 le marked other then 1", any nlury or other traumatic event, in Mas	To Be C	17. Father's Name (First, Middle, Last) Otis Shipe				18. Mother's Name Helen	Ward	iden Sumame)	
	and 2 sho ealth and I n 27 le me		19a. Informant's Name/Relationship (1 Lowell McMullen -		10	lailing Address (Street of Tulip Cou	urt, Hage	rstown, M		
	Baltimore, permit. Pages 1 ar Department of Hea mportant: If item any injury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	')	cemetery,	isposition (Name of crematory or other place cown Cremat	ory 4/7/		c. Location - City	or Town, State
	Ball permit Depart import	9000 9000	21. Signature of Euneral Service Licen	Mus	meel	22. Name and Address	on Blvd.,		own, Md.	21740
	Pnysicia /Medica		23a. Part1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	EPSIS	enter the mode of dyin	g, such as cardiac o	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Examine	er	Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	ENAL s a consequence of)	FALLU	E			40
	8760, sate be executed obysician and the burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	is a consequence of):	COLITY FALL	15			2D 40,
	Records, P.O. Box 68 The law requires that the death certifica the has been signed by the attending ph sage 2 should be detached for use as it	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknowh		ne of pregnancy 2 ⊡ Fetal death at time of death	3□Ectopic pregnancy 5□ Other (specify)			23d. Date of o	delivery Day Year
S. Tr.	cords, P v requires that been signed b	by	Part If. Other significant conditions or	ontributing to death	but not resulting in th	e underlying cause give	en in Part I.		_	to the cause of death? Probably 4'-Unknown
E vel	10 4	Completed						24a. Was an autopsy performed	prior t death	
ne mullen,	Division of Vital F or Attending Physicien: The after death. Director: After this certificate in by the funeral director, pag	ertification; To Be	27. Manner of Death 1 Substitutal 2 Accident 5 Pending investigation		jury 28b. Tim	e of 28c. Injury	at Nursing Hor	n (Check only one) me 5 ☐ Residence 28d. Describe how i		pecify)
CM	E Paritie	O	3 Suicide 6 Could not be 4 Homicide determined	289. Place of I	njury - At home, farm etc. (Specify)	street, factory, office		28f. Location (Stree City or Town, S	t and Number or itate)	Rural Route Number,
8	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2/ Medical Exam	ysician: To the bes iner: On the basis and manner s	of examination and/o	eath occurred at the tim r investigation, in my op	pinion, death occurr	ed at the time, date	and place, and d	ue to the cause(s)
	5 × × 5 × 2		29b. Signature and title of certifier	2		29c. License	232	3	Date signed (Mo	(Hay, Year)
	EX.		30. Name and address of person who of	1/26 (Ipal Cou	pe. Print)	nd			
	Regi	State strar	31. Date filed (Month, Day, Year)	004 32. Hagis	trar's Signature	Sperke				

			1 - For State Registrar	State of M	arylan		artment rtificate					giene 20	04	13	285
	Physici		1. Decedent's Name (First, Middle, La Violet Virgi:		^						2. Date of Dea Month April	Day 6 20	Yeer	3. Time 6	of Death
4	/Medio Examir		4e. Facility Name (If not institution, giv 62 Redwood Dri	e street and number)					Location of		MPTTT	4c. County	of Death		
28	Funeral		5. Social Security Number 6. S	Sex 7. Ac	e (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth	1	9. Birthp	OD Ci eleca (State etry)	ounty or Foreign
ь	Director		232-28-0033	□м 22 F	9	0 Yrs.	Months	Days	Hours	Min.	(Month, Day uly 20		Mar	ylan	đ
	pu 🗼		Usuel Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						1	0d. Inside (City Limits
	Maryla -f sho	tor	Maryland Washi	ngton		Hagers									s 2 No
	r 28a	Director	10e. Street and Number				10f. Zip	Code				I0g. Citizen of \	Whet Cour	ntry?	
	h with	a D	62 Redwood Drive	9			21	1740				U.S.A.			
336	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural; or Items 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status ¡XXVever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U No			ent of His	spanic Origin, Mexican Specify:	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14. Rac Blac	e - Americk, White,		
21215-0036	72 hou	Completed	15. Decedent's E (Specify only highest gra			(Give	dent's Usua kind of wor	k done di	urina most	t of working	na	16b. Kind of B	usiness/In	dustry	
2	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOTUS Chauff	e retired)				n-41			
	ited w tygier ther ti		17. Father's Name (First, Middle, Last	1		1	JIAULI		18 Mothe	r's Name	(First Middle	Rail Maiden Suman			
Maryland	iould be filed within Mental Hygiene. Parked other than	To Be	William Moore	,						y Loi		walden doman	,,		
N.	should nd Men marka	٦	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a				r, City or Town,	State, Zip	Code)	
	and 2 Balth a n 27 la		Betty J. Sagle/ne	eice		62 Re	edwood	d Dri	ve.	Hager	stown.	Maryla	nd 21	740	
ore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			Place of Disponentery, crea	sition (Nam	e of		Di	ate	20c. Location -	City or To	wn, State	-
Ĕ	Peges ment of ant: If it		`4 ☐ Donation 5 ☐ Other (Special		Gre	eenlaw				pril	9, 04	Willia	amspo	ort, M	aryla
Baltimore,	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if item 27 is marked other than any injury or other traumatic event, the Magnes.		21. Signature of Funeral Service Licer	Ting		13	331 Ea	ster	n Bl	vd. N	N. Hage	Fiery : rstown,			
	Physician /Medical Examiner) l	23a. Part 1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a. Due to (or as	e. ERT a conseq	DNS/		_				est, RDIS	EASE	Approxima Interval Be Onset and	ate etween I Death
,0928	The law requires thet the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infilated events resulting in death) Last	c. Due to (or as											
P.O. Box 6	thet the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 De No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	ildeath 3□	Ectopic pre Other (spe					23d. Dai Mo	e of delive	ory Day	Year
	w requires thet been signed b should be deta	þ	Part II. Other significant conditions of	contributing to death b	out not res	ulting in the u	nderlying ca	ause givei	n in Part I.			bacco use cont es 2 □ No	nbute to th		death? (Unknown
Records,	yysicien: The law requ nis certificete has been I director, page 2 shoult	Completed	N							_	24a. Was a autops perform	med?	prior to con death?	psy findings npletion of 2 No	available cause of
Vital		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or				
of V	Physicien: this certific ral director,	10	1 □ Yes 2 No	Hospital: 1 Inpati		ER/Outpatier		-	4 LI Nu	rsing Horr	e 5 ⊠ Reside	ence 6 🗆 Oth	er (Specify	1)	
o uo	ding After fune	atlon;	27. Manner of Death 1 (5 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M 28	3c. Injury Work′ 1 □ Y	at ? es 2 □ !		8d. Describe h	ow injury occurr	ed		
Division	i git e	Certification;	3 Suicide 6 Could not be determined		jury - At he c. (Specif	ome, farm, str	eet, factory,	, office		2	8f. Location (Si City or Town	treet and Numb n, State)	er or Rura	l Route Nur	mber,
	To the Hospital or within 24 hours afte To the Funeral Dircompletely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	nysician: To the best miner: On the basis o and manner st	of examina	wledge, death tion and/or in	h occurred a vestigation,	at the time in my opi	e, date and inion, deat	d place, a th occurre	nd due to the c d at the time, d	ause(s) and ma ate and place,	nner as st and due to	ated. the cause((s)
	To the To the Comp	M	29b. Signature and title of certifier		>		29c.	License			2	9d. Date signed	(Month,	Day, Year)	
	,		On	8	~			0:	523	23		4/7/	04		
, \	1-5		30. Name and address of person who	completed cause of	death (Iten	п 23а) (Туре,	Print)								
9	('		Khalid M. Wasee		al C	ourt	Hagers	stowr	ı, MD	. 217	740				
	Sta Regist		31. Date filed (Month, Day, Year) APR 08 2	32. Registr	rar's Signa	il. Ap	artes								

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryla		artment of He tificate of D			iene 2004	13287	
H	Physicia /Medic		1. Decedent's Name (First, Middle, La Martha Jane					2. Date of Deat Month March	Day 14 200	3. Time of Death	
	Examin		4a. Facility Name (If not institution, given Washington Count 5. Social Security Number 6.5	y Hospital	rs. last birthday)	4b. City, Town, or Ha If Under 1 Year	agerstowr If Under 24 Hrs.			h ington hplace (State or Foreign untry)	
	Funeral Director		214-09-7065	1□M ¾XXF	86 Yrs.	Months Days	Hours Min.	(Month, Day, 0ct.26,1	1917 Co	lary land	
ryland	show d.m.		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes ※XXNo	
h the Ma	r 28a-f	Directo	Maryland Washi 10e. Street and Number	ngton		lagerstowr 10f. Zip Code	1	1	0g. Citizen of What Co		
ath wit	23a o	ralD	17617 Heisterbo				21740			ISA	
rs after de	if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic evant, Ite Modical Exactiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1		Mas Decedent of His f Yes, specify Cubar I □ Yes 2☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	DECITY YES OF NO- D Rican, etc.)	14. Race - Ame Black, Whit Specify:		
hin 72 hou	an "natura Madical E	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of work	king	16b. Kind of Business/		
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	th and it		19a. Informant's Name/Relationship Clayton W. Miller	**		g Address (Street a reston Dr			City or Town, State, 2		
es 1 and	of Health fitem 27 r other tr		20a. Method of Disposition 1XXSurial 2 □ Cremation 3	200	b. Place of Dispo			and the same of th	ginia 241 20c. Location - City or		
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		ľ	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. SECTIC COROMA SER INFO 15						15 YEARS		
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cate be executed		dlcal	l	d							
O. DOX O.	with the propriet of washing in parents. The law requires that the open community in the Purnous after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnapt in the past 12 months? 1 ☐ Yes 2 ₺ ₩ 6 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown					23d. Date of del Month	ivery Day Year	
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dina Phys		tlon: To	1 Yes 2 No 27. Manney of Death 1 Matural 5 Pending 2 Accident investigation	28c. Injury Wark	A 4 Autising Nome 5 Residence 6 Dotner (Specify)		oify)				
DIVISION ALL		Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		at home, farm, str ecify)	street, factory, office 28f. Loc			ation (Street and Number or Rural Route Number, or Town, State)		
Hospits	24 hours a Funera etely filler	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Tothe	within Compl	29b. Signature and title of certifier 29c. License number							29d. Date signed (Month, Day, Year)		
	13N	1	30. Name and address of person who	completed cause of death (I	hypcian Item 234) (Type,	Print)	0004	159	MAR 1	5 04	
5	0/1		PORTERT BRU(-MD 1459	POTOF	HAC ST.	NAG	ERSTOW	N, MD 2	1742	
	Sta Registr		NAR 16	32. Registrar's Si	M. An	was					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:45 AM HARRY A MILLER 10 April 2004 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner SALISBURY SALISBURY
If Under 24 Hrs. 8. Date REHAB & NURSING CENTER WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**K** M 2□ F Months Hours Min. Yrs. Director 148-16-2898 02/21/1926 New Jersey Usual Residence of Decedent 2 should be filed within 72 hours efter death with the Marylend and Mantel Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov 1 ☐ Yes 2 🔀 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 30434 Southhampton Bridge Rd. 21804 items 23a USA Completed by Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 Mas Decedent of Hispanic Or
If Yes, specify Cuban, Mexican
If Yes, Give CoastGuard

1 □ Yes 2 No Specify: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0020 ծ Specify 3 ☐ Widowed 4 ☐ Divorced white other than "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N.American Philips 4 Senior Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked David Martin Miller Madalene E. Emery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy J. Miller/wife 30434 Southhampton Bridge Rd., Salisbury,MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4/13/04 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 0 Examiner Due to (or as a consequence of): Physician/Medical Examiner 0 0 or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 2 - cm Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 11 Yus 2110 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2[1 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this eral Director: After this fillad in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after daath. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🚅 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760,

MILLER

HARRY

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

a

29b. Signature and title of certifier

31. Date filed (Month,

HEALTHWAY

32. Registrar's Signature

29c. License number

SALISBURY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Daath Month Year **Physician** Floyd Martin Mahan /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and numbar) 4c. County of Death Examiner e CAM If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Yaar) If Under 1 Yaar 7. Aga (In yrs. last birthday) 5. Social Sacurity Numbar 6. Sax **Funeral** Months Days 1⊠M 2□F Yrs. 220-22-0950 Director 92 March 11, 1912 Maryland Usual Residance of Decedent 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Depentment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notitied at 1⊠ Yas 2 No Directo MD Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 402 Lorraine Street 21001 U.S.A. Funeral 12. Was Dacadant Evar in U,S. Armad Forces? Was Decedant of Hispanic Drigin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 X No Specify: Specify: White Completed by 3 ₩ Widowad 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Efamantary/Sacondary (0-12) Collega (1-4or 5+) 12 0 Civil Service U.S. Government 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) James A. Mahan Grace L. Streett 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Typa, Print) Beverly Hawes (Daughter) 402 Lorraine St., Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1X Buria! 2 ☐ Cremation 3 ☐ Removal from State 4/15/04 Aberdeen, MD Harford Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signatura of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. 333 S. Parke St., Aberdeen, MD 21001-3399 23a. Part1. Enter the disease, or complications that caused tha daath. Do not enter tha moda of dying, such es cardiac or raspiratory arrast, shock, or heart failure. List only one cause on agent line. Approximate Interval Between Dnset and Death **Physician** Immadiate Cause (Final disaase or condition resulting in death) /Medical several Examiner Due to (or as a consequence of) Physician/Medical Examine the Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or es a consaquance of): ĕ Division of Vital Records, P.O. Box 68760, Dua to (or as a consaguanca of): 23b. Did tobacco usa contribute to the causa of death? Part If. Other algnificant conditions contributing to death but not rasulting in tha undarlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ Mo Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? 1 Yes 24 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 T 4 Ursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 2 : After this of funeral dir 28a. Data of Injury (Month, Day Yaar) 27. Many r of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of Certification: 5 Panding Natural 1 ☐ Yas 2 ☐ No within 24 hours efter deeth.

To the Funeral Director: Af invastigation 2 Accident 6 Could not be datarminad 3 Suicida 28f. Location (Streat and Numbar or Rural Route Numbar, City or Town, State) 28a. Place of Injury - At home, farm, straet, factory, offica building, afc. (Spacify) à 4 Homicide edicai 29a. Certifier Certifying Physician: To tha best of my knowledge, daath occurred at tha time, date and place, and due to the causa(s) and manner as statad.

| Medical Examiner: Do not be basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier

State Registrar

30. Nama and addrass of person who compl

Data filad (Month, Day, Yaar) 2004

ted causa

daath (Item 23a) (Type, Print)

MD

Mary Murph

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 6:12A M MARGARET MARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGES If Under 1 Year If Under 24 Hrs. Months Days Hours Min. OCT. 5, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 76 Yrs. ΜĎ Director 577-34-8055 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "neturel", or Items 23s or 28s-f show other treumstic event. The Madical Examinar must be notified at 1 XYes 2 No Director MD PRINCE GEORGES LANDOVER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6408 COUNTRY CLUB CT 20785 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE þ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "ne any injury or other treumatic even" Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JOHN M. HICKEY MARGARET A. HICKEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) THOMAS MURPHY/ SON 730 60TH AVE. FAIRMOUNT HEIGHTS, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State GATE OF HEAVEN CEMETERY 4/2/2004 SILVER SPRING, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 21. Signature of Funeral Service Licensee BOWIE, MD 16000 ANNAPOLIS ROAD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician 01/2/6 disease or condition resulting in death) /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans 40 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2. No 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s after death. 1 Yes 2 No Accident 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Groud Cuck Kd THOMAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 13291 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** McConnell, Bernard Jr. 8:00 PM MAKEH 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctors Community Hospital Lanham
If Under 1 Year | If Under 24 Hrs. | Prince Georges **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1**∑**M 2□ F 577-46-2619 69 Yrs. Director Aug. 3, 1934 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examiner must be notified at Director YYes 2 □ No Maryland Prince Georges Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20737 6707 Furman Parkway 'neturel', or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No IVYes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "neturel", or Ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No þ Specify: 3X Widowed 4 □ Divorced Year or Dates: 1955-58 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Head Lineman Pepco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be McConnell Mary Edward Bernard Frances Moynihan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, Maryland Julie Kelly/ Daughter 12512 Windover Turn, 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Silver Spring, injury or Gate Of Heaven Cemetery 3/29/2004 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses any 16000 Annapolis Road, Bowie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ruspin. fo **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AUPOTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine stdone Antic The law requires that the death certificate be executed Kuptuned Division of Vital Records, P.O. Box 68760, Physiclan/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Director: After th 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7233 HANDUER PARKWAY GREENDELT, MD AYLY H.D. 2 istrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 001 13292 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 25, 7:00 PM Lottie Moon March 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rose Manor Assisted Living Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 💆 F Yrs. 86 19, 1917 Massachusetts Director 128-34-8771 Usuel Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Expediment count be notified at 1 ☐ Yes 2 ☐ No Director Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? death with or items 23a or 3100 N. Ridge Rd. 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3€ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Healthcare 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth any jury or other traumatic event SDEs. Mary Todzia Wladvslaw Mlynarski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Woltjen/Daughter 1797 Lasalle Place Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/26/2004 Metro Crematory Catonsville, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Lice M00845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Failure to thrive 9 months /Medical Due to (or as a consequence of) Examiner Right Heart Heart Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Chronic resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Depression 24b. Were autopsy findings available prior to completion of cause of death? Fibrillation 24a. Was an autopsy performed? Yes 21/11/No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes S No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) To the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D58747 Mach 26, 2004 30. Name an address of perso o completed cause of death (Item 23a) (Type, Print) Randal Riesett 10700 Charter Dr. Colombia MD 21044 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 6 2004

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month March 25^{Day} **Physician** 2004 8:00 A M Myrtle M. Manning /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard West Friendship 13220 Frederick Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV 21, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 XF Hours 1924 Maryland 79 219 12 5722 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10b. County 1 ☐ Yes 2 No Directo West Friendship MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ir than "natural", or items 23e or the Medical Examinar must be United States 21794 13220 Frederick Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No !! Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene.
ant: If time 27 is marked other than "natural; or flee ury or other traumatte event, It is the clicit Essa integruy or other traumatte event, It is the clicit. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: 3 ₩idowed 4 Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Myrtle Maddline Neveker Henry Martin Schueler Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13220 Frederick Road West Friendship, MD 21794 Yvonne Feilinger/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it sny injury or o QDCs. Depertment of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gard.3-27-2004 Bel Air, MD permit. 0M01044 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 WKK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** EM n. West Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a o nseque ce of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): anding physicien a use as the burial-Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ģ Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by should b Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has s certificate ha autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To funeral dir After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier t 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) polis Rel #202 Effect City MO21042 WOORUBET 952 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 2 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month 8137 RM **Physician** Robert D. McBain 11. 2004 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 198-14-0056 79 12/15/1924 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at PΑ Tioga 1 ☐ Yes 2 No Mansfield Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö Route 1, 16933 Box 232 USA or Iteme 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. filed within 72 hours after 1X) Yes 2 □ No 1943— If Yes, Give Year or Dates:1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify:White by 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) 4+ Field Representative Social Security Admin. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other you good any jury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Drexel McBain Unknown Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy McBain/Wife 5057 Ten Mills Road, Columbia, MD21044 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory 4/13/2004 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H., Inc mobile! 4112 Old Columbia Pike, Ellicott City, MD 21043 MOO845 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Atherosderotic Cardiovascular Disease Physician cars /Medical Due to (or as a consequence of): Examiner H pertension
Due to for as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform med? 20 No 36 No certificate 1 Yes 1 🔲 Yes 25. Was case referred to medical examiner?
10 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Outpatient 3 DOA ဥ 1 Inpatient this I Director: After this of in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 September 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April (5)0°3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4565 Hemlock Cone Way PATRYCE A. TOYE 31. Date filed (Month, Day, Year) APR 13 32 degistrar's Signature State Registrar

			1 - For State Registrar	State of M	Maryland			of Health a of Death	and Me		iene 2 (004	13295
	Physici /Medio		1. Decedent's Name (First, Middle, L Joyce Everett Mc							2. Date of Deat April 5		Yeer	3. Time of Death 8:35 a.m.
A	Examir		4a. Fecility Name (If not institution, g 110 Railroad Ave 5. Social Security Number 6.	nue	ar) Age (In yrs. Ia	st hirthday)	4b. City, Tow Bard If Under 1 Yo			3. Date of Birth		een A	nne's
	Funeral Director		217-42-5719 Usuel Residence of Decedent	1□M 21XF	65	Yrs.		ys Hours	Min.	(Month, Day, 07/14/1	Year)	Mary	itry)
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Esammer i unst by modified a	ector	10a. State 10b. County Maryland Queen	Anne's		Town or Lo	У						0d. Inside City Limits Yes 2 □ No
	th with th	Funeral Director	10e. Street and Number 110 Railroad				10f. Zip Coo 21	1607		11	0g. Citizen of V USA	Vhat Coun	itry?
36	irs after dea il', or Items	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1	s? ₹No	11	Vas Decedent Yes, specify (of Hispanic Orig Cuban, Mexican No Specify:	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	Blac	e - Amenc ck, White, c	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "natural", or items 23a or 28a-1 show any injury or other traumatic event, its Medical Examination in the profiled at Once.	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)		or 5+)	(Give l	OO NOT use re	one durina most		7	16b. Kind of Bu		dustry
Maryland 2	uld be filed v Aental Hygie rked other I tic event, th	To Be Co	12 17. Father's Name (First, Middle, La Newell B. Everet					18. Mothe	r's Name (First, Middle, M			
	and 2 should lealth and Men m 27 is marke		19a. Informant's Name/Relationship Spencer Everett/B					eet and Numbe Sudlersv					Code)
Baltimore,	Pages 1 annent of Herint: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		te <i>cer</i>	metery, crem	sition (Name of natory or other 11e cEm		4/09/		oc. Location - Sudlers		wn, Stete e, Maryland
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	effenle	i)	22.	Name and Ad	dress of Facility	y				ome, P.A.
8760,	Physician /Medical Examiner physician and physician and physician	al Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a Due to (or a c.	on the death. on the death. on the death. on the death. on the death. on the death. on the death. on the death. on the death.	ance of):	LINS Huc	Lyn Lyn	Pu	espiratory arre	m (lise	Approximate Interval Between Onset and Death
O. Box 687	death certific e attending p id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past R months? 1 \(\text{Yes} \) 2 \(\text{D} \) No 9 \(\text{Unknown} \)		2 Fetal of at time of dea	death 3 🗌	Ectopic pregna Other (specify				23d. Dat	e of delive	ry Day Year
S, P.	sign d be		Part II. Other significant conditions	s contributing to death	but not result	ting in the un	derlying cause	given in Part I.				ribute to the	e cause of death?
Vital Record	: The law requ cate has been , page 2 shoult	Completed							_	24a. Was an autolasy perform 1 Yes 2	ed?	rior to cor leath?	psy findings available appletion of cause of
Z Z	Physicien: rthis certificated frail director, i	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpa	itient 2 TF	R/Outpatient	3□ DOA	Othor	of Death (Check only one	nce 6 □Othe	or (Specify	1
Division of	To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; T	27 Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of In (Month, D		28b. Time of Injury	28c. I	njury at Work? 1 Pes 2 N	28	d. Describe hor			,
<u>X</u>	ital or Att is after de ral Direct led in by t	Certific	3 ☐ Suicide 6 ☐ Could not determine	289. Place of I	injury - At hom etc. (Specify)	ne, farm, stre	et, factory, offi	C8	28	Location (Str. City or Town,	eet and Numbe State)	or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical	29a. Certifying F (Check only one) 2 Medical Ex-	Physician: To the bes aminer: On the basis and manner	of examination	ledge, death on and/or inv	occurred at the estigation, in n	e time, date and ny opinion, deat	d place, and h occurred	d due to the ca at the time, da	use(s) and ma te and place, a	nner as sta and due to	ated. the cause(s)
)	To the within 2 To the complete	Z	29b. Signature and title of certifier				29c. Lic	ense number	186	29	d. Date signed	(Month, D	Day, Year)
_			30. Name and address of person when Andrew Feve	guson M	1) 120	Spe	Print) RI)	Suite	eII (Ches-	tertou	n l	1021620
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 0	7 2004 32. Re	trar's Signatu	J.	book				•		

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** Josephine Brown Metcalfe-Lane March 27, 2004 5:45p. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chester River Manor Chestertown Kent If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 04/16/1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number **Funeral** 1 □ M 2 🔀 F 77 184-22-2948 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or Iteme 23e or 28e-1 ehow traumetic event, the Macilcal Examiner must be notified at 1 ☐ Yes 2X No Director Millington Maryland Oueen Anne's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21651 USA 209 Red Lion Branch Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White 3 ♥ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker OWn Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be in Mary Cary Harrison Challice Hayden Metcalfe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 le m any injury or other traum once. 209 Red Lion Branch Road, Millington, MD 21651 Challice Webb/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2XX remation 3 ☐Removal from State
4 ☐Donation 5 ☐Other (Specify) Chesapeake Cremation Center March 30, 2004 Stevensville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newmann Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651 been Fellows 23a. Sant1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final renal falive Inouth **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner hyperturian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner diner The law requires that the death certificate be executed Commany artu burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year detached for 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be Clartic stenosis 1 Yes 3 ☐ Probably 4 ☐Unknown 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No page 2 s history of alchelism in the past 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 safter dee.
rat Director: After u.
tv the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be within 24 hours after de To the Funeral Directo completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed, (Month, Day, Year) 29b. Signature and title of certifier 3/29/04 10054890 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chien him mys 21620 4602 Chich the Kd ideather Morph MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 29, Day 2004 **Physician** Jack M. Meyer 1:20a.mM /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Chestertown Kent Chester River Hospital Center 8. Date of Birth (Month, Day, Year) 5/03/1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign 5. Sociel Security Number 7. Age (In yrs. last birthday) Days Hours 1**∑** M 2□ F 79 Pennsylvania 180-14-9339 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No Director Maryland Kent Rock Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4859 Skinners Neck 21661 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? NCW'es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Press Man Technical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah Wylie Marcel Jacques Meyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4859 Skinners Neck Road, Rock Hall, MD 21661 Mary Ellen Meyer/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Chesapeake Cremation 3/30/3004 Stevensville, Maryland 21. Signature of Funeral Service Licensee Fellows, Helfenbein & NEwnam Funeral Home, P.A. PART LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week Respirator failure Due to (or as a consequence of): Small Coll Lience Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Motostatio CAMORY! Colon CAMORY! HTIN 9/8600410 1 ☐ Yes 2 ☐ No 3 Probably Be Completed Certification; To

Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, detached filled in by

Funeral

Director

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rthan "naturel", or Itema 23a or 28a-f ebov the Medical Examiner must be nulified at

d other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lipiny or other traumatic event once.

Physician /Medical

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Poriphoral Voscul			; Co		D ₃ 2	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical				26. Place of	Death (Che	eck only one)	
examiner? 1 Tes 217 No	Hospital: Inpatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursin	g Home	5 🗆 Residence	B ☐Other (Specify)
27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	Injury at Work? 1 Yes 2 No	28d. [Describe how injury	y occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street fy)	, factory, o	ffice		ocation (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledge, death or	ccurred at	the time, date and pl	ace, and d	ue to the cause(s) the time, date and	and manner as stated. place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number DOSO996 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Brown St. Stoddard

and manner stated.

Chestertown, mD 21620

State Registrar

Medical

(Check only one)

31. Date filed (Month.



State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year **Physician** FILBERT MOORE March 29 2004 3:15a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Wing / Heron Point Chestertown Kent Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, May 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Months Davs Hours 1**⊠** M 2□ F 213-38-8246 92 May 1911 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show 17 is marked other than "neturel", or Items 23e or 28e-f shot traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Heron Point 21620 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "neturel; or Ite 1XXYes 2□No 1953 If Yes, Give Year or Dates: _1955 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. White Specify: þ 3 Widowed 4 Divorced -1955Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 +Dentist Self-employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be J. Randolph Moore Laura Filbert ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol M. Gjellstad (daughter) 60 Nicoll St. New Haven, CT. 06511 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cem. 3/31/04 Baltimore, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice Gallena Tuneral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 23a. Part 1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CINCESTIVE HEART FAILURE

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** 1 ears /Medical Due to (or as a consequence of): Examiner DROWARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ■ No 24a. Was an has autopsy performe certificate DE No 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) ٩ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division Natural 2 Accident 5 Pending 1 □ Yes 2 □ No within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 | Homicide Filled Hospitel Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) å 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 004158> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 122 Speer Rd. Chestertown, $M \cdot D$. Noble, Helen A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Brew & Apolle MAR 3 0 2004

DHMH 17 Rev 1/2001

			For State Registrar	State of		epartment of F			giene 2	004	13299
			Decedent's Name (First, Middle,	Last)				2. Date of De	ath		3. Time of Death
	Physici /Medic		John	Thomas		Jannina .	C.	Month	20 7	Year	0245 M
3	Examin		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, Town, o	r Location of Deat	h	4c. Cou	nty of Death	-
			Chester Rive	5 Hospit	tal Cent	er Chest	ertown	1	KG	ent	
I	Funeral Director		5. Social Security Number 212–18–6198	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last birti	nday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da 10/06	th ly, Year) 1917	Coul	place (State or Foreign ontry) 7land
	pu ,		Usual Residence of Decedent		10. Ch. T						(0.1.1
	show	_	10a. State 10b. County	,	10c. City, Town						10d. Inside City Limits
	8e-f	Director	Maryland Queen A	nne.s	Sudle	rsville					1. Yes 2 No
	with t	ä	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coul	ntry?
	s 23	erai	103 West Main S	12. Was Decede	ant Ever in II S	13. Was Decedent of H		pacify Vac or No	USA	Race - Americ	can Indian
36	d within 72 hours after death with the Maryland jiene. I the "neturel", or Items 23a or 28e-f show The Mazical Examiner must be notified at	y Funerai	11. Marital Status 1 Never Married 2 Marrie	Armed Force ad 1 ☐ Yes 2 If Yes, Give	es? X No	If Yes, specify Cuba	an, Mexican, Puerl	o Rican, etc.)	E	Black, White,	etc.
8	urei	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date							
21215-0036	n 72 "net	Completed	15. Decedent' (Specify only highest	t grade completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of wor	king	166. Kind 0	f Business/In	dustry
12	within lene. then "	m _o	Elementary/Secondary (0-12)	College (1-4		ool Bus Con			Mwana.	~~~+~+	
ğ	e filed withing Hygiene.	BeC	17. Father's Name (First, Middle, L	.ast)	DCII	OI DUS COIL		ne (First, Middle,		portat name)	TOU
Maryland	nould be d Mental narked o	ToB	John Thomas Man	ning			Arabell	le Travi	S		
ary	shot and N		19a. Informant's Name/Relationsh	-	19b.	Mailing Address (Street				wn, State, Zip	Code)
Σ.	and 2 salth a 1 27 I er tre		Nancy Whalen/Da	ughter	PO	Box 251, C	rumpton,	Marylan	d 2162	8	
Ore	of He fiter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Pemoval from St	cemeten	Disposition (Name of r, crematory or other place	ce)	Date	20c. Location	on - City or To	own, State
<u>Ĕ</u>	Pag ment ent: I ury o		'4 □Donation 5 □ Other (Sp		Asbury	Cemetery	3/26	5/2004	Milli	ngton,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Importent: If item 27 is marked other any njury or other treumatic event, and.		21. Signature of Funeral Service L	ellouts		22. Name and Addre FEllows, He 370 W. Cypi	elfenbeir	1 & Newn	am Fun	eral H	ome, P.A.
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cau	sed the death. Do n	ot enter the mode of dyin	ng, such as cardia	or respiratory a	rrest,	LI, III	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	0 -	enmonia						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of		. 1				11 .57
	_xao.	ايا	Sequentially list conditions,	b	as a consecuence of		mentin				1 YEAR
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	cate be executed physician and the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or	as a consequence o	f):					- vect
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õ	tificat g phy as th	ed						-			
Вох	death certifica e attending ph od for use as t	ician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy	3 □Ectopic pregnancy	,		t t	Date of delive	*
		/sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		it at time of death	5 Other (specify)				Month	Day Year
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Ö	w requi	lete						24a. Was	an 24	h Were auto	psy findings available
Rě	elav has je 2	Completed						autog	rmed?	prior to cor death?	mpletion of cause of
æ		ပိ	25. Was case referred to medical				as Piage of Dec	1 ☐ Yes ith (Check only o	2200	1 🗆 Yes _	21 No
>		To B	examiner?	Hospital:	atient 2 ER/Out	patient 3 DOA Oth	00	ome 5 Resid		Other (Specifi	v)
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jo	Attending ir death. ector: Aftei by the fune	atio	Natural 5 Pending 2 Accident investig		Day (Gai)		Yes 2 □ No				
Division of Vital Records,	i Sir de	ertification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 286. Place of	Injury - At home, far , etc. (Specify)	m, street, factory, office		28f. Location (S City or Tox		mber or Rura	l Route Number,
_	한 수 필 등	edical C	(Check only 2 Medical E	xeminer: On the basi	is of examination and	death occurred at the tin for investigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as st	ated. o the cause(s)
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and little of certifier	and manner	sidieu.	29c. Licens	e number		29d. Date sig	ned (Month.	Day, Year)
	5 1 8 H			^	AD	3	51735	FT30	3	22/01	49
7			30. Name and address of person v			Type, Print)	. , ,		- 1		1
			Frederick Delb	· ·	, , ,	ill Road, C	hesterto	wn, MD	21620		
	Sta	ite	31 Date filed (Month Day Year)	32 Ben	ist 's Signature						
	Registr	rar	MAR	2 5 2004	Alder L	* South					

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			1 - For Stete Ragistrar				Ce	rtificate of	Death		R	eg. No.		7 1000
	Physici		1. Decedent's Name (First, Mic	dle, Last)						2	Month	Day 6	Or/	3. Time of Death 320 A-M
	/Medic Examin		4a. Facility Name (If not institu		reet and nun	nber)		4b. City, Town,	or Location of	of Death		4c. Cou	nty of Death	
	Examil	iei	UNIVERSITY OF	_		1		_	MORE			C		
-	Funanal		5. Social Security Number	6. Sex	MLAND		o C+K.				Date of Birth (Month, Day)		a Right	place (State or Foreign
1	Funeral Director		217-20-6855	1 2 0 P	M 2□F	3 , ,	82 Yrs.	Months Days	Hours	Min.	(Month, Day,	Year) 1921	Coul	rain Ginia
0			Usual Residence of Decedent				060				Apr. 24,	1761	V //	ginia
	yland Now		10a. State 10b. Cour	ity		10c.	City, Town or Lo						1	0d. Inside City Limits
	Mar Har	ţ	Virginia Acc	omac	K		Punant	Paque						1 ☐ Yes 2 🕱 No
	1 the	Director	10e. Street and Number				7	eague 10f. Zip Code			1	0g. Citizen	of What Cour	ntry?
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	ms 2	Funeral	11. Marital Status		. Was Dece		U.S. 13.	Was Decedent of		igin? (Spec	fy Yes or No-	14. F	ace - Americ	
9	after or Ite		1 Never Married 2 M	arned	Armed For	2 CTNO					can, etc.)		lack, White,	
93	ral', c	b	3 ☐ Widowed 4 ☑ Divord	ed	Year or Da	e ates: 1945.	-46	1 ☐ Yes 2 X No	Specify:			Spe	city: Bla	ck
5-0	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show disal Epacarer must be notified at	Completed	15. Deced (Specify only hig	ent's Educa	ition			dent's Usual Occu kind of work done DO NOT use retire	ipation during mos	st of working		16b. Kind of	Business/In	dustry
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P	B E D >	Be	17. Father's Name (First, Midd	e, Last)	. /	,					First, Middle, I Sav		ame)	
Уlа		ဥ	Amos		Noc	K				laggie		-		
Maryland 21215-0036	2 sh i and is m		19a. Informant's Name/Relation		•	14		ng Address (Stree						
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		Dorothy John	15cm	Vai	ighter		6 Park	Hven	ue C				
0	00		20a. Method of Disposition 1 Burial 2 □ Cremation	n 3 ∐Rer	moval from S	State	cemetery, crea	matory`or other pla				~	n - City or To	
Ë	tmen tant: jury		`4 □Donation 5 □Other			1	bly Trinit	y Brystist	Church! 1	April 16	0,2004	rungote	rique, l	irginia
Baltimore,	permit. Page Department Important: Il any Injury o		21. Signature of Funeral Servi	e Licensee	MAX	21		Name and Addr				-		
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Н			23a. Part1. Enter the disease, shock, or heart failure. L	or complica ist only one	ations that ca cause on ea	aused the de ach line.	eeth. Do not en	er the mode of dy	ing, such as	cardiac or i	espiratory arre	est,		Approximate Interval Between Onset and Death
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	Lxammer	L	Sequentially list conditions,	b.										
	sit ad	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	2	Due to (or as a cons	equence of):							
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687	leath certificate b attending physic for use as the b	dicai		d.						· · · · · ·				
9 ×	death certifica e attending phi d for use as th	/Me	IF FEMALE:	230	c. If yes, out	come of ore	mancy					1 - 1100	-7	
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P.0.	0 0 2	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9 Unkno		idealii 5	_ Other (specify) _						
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of Vital Records,				[· .			1 ☐ Yes 2	No No	1 🗆 Yes	2XNo
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on	ding h. Afte fune	tion	1 SNatural 5 ☐ Pen	ding stigation	(Mont	h, Day Year,	Injury	Wo	ork?]Yes 2.∐.l			,,		
Division	Attending r death.	fica	3 ☐ Suicide 6 ☐ Cou	-	28e. Place	of Injury - A	t home, farm, str	eet, factory, office			f. Location (St	reet and Nui	mber or Rura	I Route Number,
	after after Dire	Certification;	4 Homicide	IIIIIII G	buildir	ng, etc. (Spe	icity)	,,			City or Town	, State)		
	Hospital or 14 hours afte Funeral Dir tely filled in b		29a. Certifier 1 € Certif	ying Physic	cian: To the	best of my k	nowledge, deat	n occurred at the t	me, date an	nd place, and	d due to the ca	use(s) and	manner as si	ated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only Z Medic one)	al Examine	or: On the ba and mann	isis of exam er stated.	ination and/or in	vestigation, in my	opinion, dear	th occurred	at the time, da	ate and place	e, and due to	the cause(s)
	To the within 2. To the I complet	ĕ	29b. Signature and title of cert	fier				29c. Licen	se number		29	9d. Date sign	ned (Month,	Dey, Year)
)			& Phill	, Mi	D			PIS	389			4/6/0	4	
			30. Name and address of pers	on who com	pleted caus	e of death (I	tem 23a) (Type,					11-1-	1	
H	3+1		DAVID	A .	VITBE	2-	MD	22 5	· brice	ENF <	· T .	BALT	morE	21210
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	Registr	ar	APR 0	9 200	4 10	Sister .	As for							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Maryland / Dep	artment ertificate	of H	ealth a Death	and Me		gien Reg. N	Sample of the	04	133	01
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	Funeral		5. Social Security Number 6. S		. Age (In yrs. last birthday) If Under 1		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth			lece (State o	r Foreign
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	pu k	1	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation							1	0d. Inside Cit	ty Limite
	sho	ō	Maryland Anne Aru	ınd e 1	Annapolis								'	1 [☑ Yes	•
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36	ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is merked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be routilled at	by Funeral Director	1. Married 3 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 X Yes 2 If Yes, Give Year or Dat	es?	If Yes, specif	y Cubai	Specify:	i, Puerto R	ican, etc.)	,		ack, White,	etc.	
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Maryland	2 should be tiled within and Mental Hygiene. Is marked other than raumatic event, ILa Me	Г	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a	nd Numbe	er or Rural	Route Numb	er, City	or Town	n, State, Zip	Code)	
	and 2 baith a n 27 is		Mary Green / Nied	e	170	Dahlia	Dri	va	North	Kinge	thou	n F	RI 028	52	
Ē.	s 1 a of Hei item othe		20a. Method of Disposition		20b. Place of Disp	osition (Name	e of	9)	Da	Kings	20c.	Location	- City or To	wn, State	
Ë	Page ent c nt: If ry or		1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specification)		New Fern		or proce	ຶ່ ¦3,	/25/2	004	Kin	gsto	n,Rho	de Isl	land
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licer	·	2	2. Name and	Addres	s of Facilit	y Toh	n M. 1	_				
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II.	8		23a. Part 1. Enter the disease, or com	plications that can	used the death. Do not en	nter the mode	of dying	g, such as	cardiac or	respiratory a	rrest,	mai	JOI IS.	Approximate	9
2	Dhysisian	8 1	shock, or heart failure. List only Immediate Cause (Final	one cause on eac	on line.	-L-								Onset and D	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or	r as a consequence of):	lirje	01	1660	H				-	9 year	5
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in (- 75	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	аз а сопзециелсе ої).										
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ŏ	leath certitic attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy h 2 Fetal death 3	□Ectopic pred	ananav					23d. D	ate of delive	ry	
Ω.	deat e atte	icla	in the past 12 pronths? 1 ☐ Yes 2 █ No	4 Pregnar	nt at time of death 5	Other (spec						М	lonth	Day Y	'ear
P.0	that the de led by the a detached f	hys	9 ☐ Unknown	9□ Unknow	m										
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rd	w require been sig should b	ed l				·				10	Yes 2	2 🗌 No	3 🗌 Prob	ably 4 U	Inknown
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R	ician: The lav certiticate has rector, page 2	E						-			psy rmed? 2. X °N		death?	npletion of ca 2 ⊠ No	luse of
Vital	an: titica tor. p	BeC	25. Was case referred to medical					26 Place	of Death /	1 ☐ Yes Check only o		0	1 🗌 Yes	200 190	
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lo	nding l th. :: Alter e funer	atio	1 Natural 5 Pending 2 Accident investigation		Day Year) Injury	М	Work 1 □ Y	? ′es 2 🔲 l	No						
Division	f or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not be determined	200. Flace 0	f Injury - At home, farm, si	reet, factory,	office		28	f. Location (Street a	nd Num	ber or Rura	Route Numb	ber,
Ö	el or A s after il Direct	ert	4 Homicue	bullaing	g, etc. (Specify)					City or To	wn, Sta	(e)			
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely tilled in by the funeral director, page	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the b niner: On the bas and manne	est of my knowledge, dea is of examination and/or in r stated.	th occurred at nvestigation, in	the time	e, date and inion, deat	d place, an th occurred	d due to the d at the time,	cause(date ar	s) and m nd place,	nanner as st , and due to	ated. the cause(s)	
	To th withir To th somp	Me	29b. Signature and title of certified					number					ed (Month, I	Day, Year)	
	. 21 9		De Sille	^	10	2	38	F958	8		3/2	23/	04		
			30. Name and address of person who	completed cause	of death (Item 23a) (Type	. Print)		, , , 0			10	1	7	-	
			Daget Cincol	will 1	43 Hours	2 la	rel	#101	G ON	euton	-	MA	81113	7	
	Sta	ate	31. Date filed (Month, Day Year)	32. Rec	gistrar's Signature	7 110	a cop	7000	, vu	No.			V11-		
	Regist	2.1	MAR 2 5 2	004	March A	Coast 1									

State of Maryland / Department of Health and Mental Hygiene 2004 13302 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:00 PM APRIL ZMAN BRINGMAN ATHRYN 2904 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHESTERTOWN KENT JIMSTOWN CIRCLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F MD. 215 20 0077 Director JUNE (0 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural, or items 23a or 28a-1 show injury or other traumstic event, the Macical Examinar must be rotified at 1 ☐ Yes 2 No KENT MD Funeral Director CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 JIMSTOUN CIRCLE 21620 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE ρ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iring most of working Elementary/Secondary (0-12) College (1-4or 5+) AUTOMODICE DEACER OPERATOR OWNER permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other treumatic event 90sts. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OLIVER 116CIAM BRINGMAN MYRA CLAYTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BYFORD HORSEY COURT OZMAN CHESTERTO WID, MD NOAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) APRIL 13, 2004 114 JIMSTOWN CIRCLE CHESTERTOWN, MD. 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility 265 GREEN HERON WAY CHESTERFOLD MD 21620 MARVIN V WILLIAMS TO FUNERAL 23a. Part 1. Binter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hrome 104 fars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month certificate has been signed by the atterector, page 2 should be detached for Day Year 4 Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 1 ☐ Yes the funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending investigation death. 1 Yes 2 No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Qate signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 Washington Susink, Ross 31. Date filed (Month, Day, Year) 32. Recorrar's Signature State APR 1 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 13303 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles T. Preso Sr. 4:15-PM 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Avalon Manor Nursing Home Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1፟M 2□ F 60 Yrs. 201-34-0015 1943 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "netural", or Itams 23a or 28a-f show suical Examirer mant be rutified at Fannettsburg Pa. 1 Yes 2 No Director Franklin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16843 Scribey Rd. Box 232 17221 U.S.A Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "netur 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Homes 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas C. Preso Clara Zientek ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l 16843 Scribey Rd.Box232 Fannettsburg, Pa. 17221 Patricia A. Preso (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 12, 1 Demovator 3 Bemovator State permit. Page Department of Important: If any injury or once. St. Mary's Cemetery Doylesburg, Pa. ✓ Donation 5 Other (Spec 2004 22. Name and Address of Facility 12525 Bradbury Ave. 21. Signature of Funeral Service Li Davis Funeral Home Smithsburg, Md. 21783 emus Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Day disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-transit The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? omic SUCE TUE 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irrector, page 2 s autopsy performed' 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No ဥ All Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funerel Director; After the completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification; 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3H-15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGGESTOWN でなるがしんじ 14 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			State of Maryland / Department of Health and N 1- State of Maryland / Department of Death Certificate of Death	Mental Hygie	ene2004	13304
			Decedent's Name (First, Middle, Last)	2. Date of Death	j. 140.	3. Time of Death
	Physic /Medi		IRENE ELIZABETH POFFENBERGER	April	05 Year 200	
	Exami		4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dear	
			REEDERS MEMORIAL HOME BOONSBORO		WASH	INGTON
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Nonth Days Hours Min.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign
6	Director		Usual Residence of Decedent	OCT. 6,	1915 MA	RÝĹAND
M	lanyland ahow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
1	Mary L-f ah	ţō	MARYLAND WASHINGTON BOONSBORO			1X Yes 2 □ No
e	for death with the Maryland Hems 23a or 28a-f ahow Inst must be notified at	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
6,	th will		141 SOUTH MAIN STREET 21713		U.S.A	1
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7 98	S affe	by Fu	1 □ Never Married 2 □ Marned 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify:	riiodri, oto.)	Specify:	9, etc.
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2 2	should be to the marked of umatic even	To B	JOHN L. REEDER RUTH S.	ALEXANDER	?	
FFEnberg	2 sho and h ts ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			lip Code)
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Polimore	00		20a. Method of Disposition 1 ⊠ Burial 2 □ Cramation 3 □ Removal from State	Date 200	c. Location - City or	
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40	permit Depart Import any in		21. Signature of Funeral Service Dicentities 22. Name and Address of Facility		national	Pike
-			Relly A. Zimmerman	Boonsbor	o, Marylar	nd 21713
			23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock of heart failure. List only one cause on each line.	or respiratory arrest		Approximate Interval Between
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P.	d by t	Phy	9 LI OTIKITOWIT			
Division of Vital Records.	ires ti signe	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to	
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Jec	e law has t	Completed		24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
<u>e</u>	n: Th icate r, pag	ខិ		performed 1 ☐ Yes 2 ☐	? death? No 1 ☐ Yes	2 □ No
¥	siciar certii recto	Be	25. Was case referred to medical examiner? 1 Yes 2 2 Mo Hospital: 1 Inpatient 2 EB/Outcationt 3 DOA Other: 4 3 Mospital: 1 Inpatient 3 DOA Other: 4 3 Mospital: 1 Inpatient 3 DOA Other: 4 3 Mospital: 4			
ō	Physic related	2	1 Inpatient 2 ER/Outpatient 3 DOA 4 Horsing Hor	ne 5 Residence	6 Other (Speci	(y)
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<u> S</u>	Atter r dea ector by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 2	8f. Location (Street	and Number or Run	al Route Number.
	s afte	Certification:	4 Homicide building, etc. (Specify)	City or Town, St	ate)	
	ospit hour uners ly fille	cal (29a. Certifier (Check only) Addical Examiner: On the basis of examination and/or investigation in my opinion double occurred.	nd due to the cause	s(s) and manner as s	stated.
	To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) and manner stated.	d at the time, date	and place, and due t	o the cause(s)
	To Tro I	2	29b. Signature and title of certifier 29c. License number		Date signed (Month,	
	n		D 18019	AC	RIC 6, 2	004
	5H-1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2 / 201	// 100 U// 70	
			Dr. Zafar Malik 20311 Lappans Road Boonsboro, 11. D. 21/13 31. Date filed (Month, Day, Year) 32@Registrar's Signature	5 / 301-	432-84/U	
	Sta Registra		31. Date filed (Month, Day, Year) 32 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 13305 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Purnell 4:22 AM 3 arolize /Medical 4b. City Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Gereral Bestin Mayland HUSPITA Atlante If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2🖾 F Yrs. 1932 Virginia 220-34-9851 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23e or 28e-f shor 1 ☐ Yes 2 ☑ No Directo Maryland Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 799 Healthway Drive 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: ě 3XXWidowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Families 10th laborer/domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Snead Flossie Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7348 Rocky Road - Liverpool, NY 13090 Karen P. Chisholm/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If ite any injury or of 20059. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 04/10/2004 St. Paul Ch. Cemetery | Berlin, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PSI Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): of henodialysis cathetes **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by disease 3 ☐ Probably 4 ☐ Hinknown 1 ☐ Yes 2 ☐ No heosclerotic heart disease 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? deabetes mellitus 1 Yes 2 40 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ို 2 ER/Outpatient 3 DOA 1 ☐ Yes 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide I 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, P.O. Box 68760,

show

Maryland 21215-0036

Baltimore,

230-34-985

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MD 32. Registrar's Signature APR 08 2004

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

1209 COASTAL HIGHWAY, FENUICK ISLAND, DE 19944

C1-0006795

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien) 13306 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** April 1055PM 10 2004 Joseph Μ. Puskarich /Medical 4b. City. Town, or Location of Death 4c County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, 2/2/18 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2□ F 328-05-8079 86 Yrs. Director Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 √2 Yes 2 □ No MD Harford Aberdeen Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 642 Andrews Road 21001 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No WWII If Yes, Give Year or Dates:Korea Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status be filed within 72 hours after dital Hygiene. I Other than "natural", or ttem 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White ⋧ 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Criminal Investigation Dept. Investigation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 Ia marked ott Be Daniel Puskarich Amelia Pavletich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau once. T. Pete Oiderma (step-son) 300 Donora Blvd., Fort Myers Beach, FL 33931 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdns4/16/04 Aberdeen, MD 22 Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St., Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Pnysician 3 months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examine certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical the use as 1 attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown peeu 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has b director, page 2 s 1 ☐ Yes 2/2/No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 DiNatural 5 Pending 1 ☐ Yes 2 ☐ No M investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 11, 2004 H0054439 CA Ewini(30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1 602 South Atwood Rd. Bel Air, MD Vincent A. Giminaro Do. 31. Date filed (Month, Day, Year)
APR 1 5 2004 32. Registar's Signature State Gleen & Sperke Registrar

DHMH 17 Rev 1/2001

PUSKO RICH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 13307 State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 25 2004 mesto 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) BALTIMOR N/A TOSPITAL JUHUS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 13 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 157M 2□ F Yrs. 213-64-1472 50 Ĩ′953 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d, Inside City Limits 1 ☐ Yes 2X No Maryland Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 21044 USA 5616 Vantage Point Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes ANO Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Musician Producer</u> Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Phillips Ana McSween 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ana Phillips (Mother) 5616 Vantage Point Rd. Columbia, Md. 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3-30-04 * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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should be not and Mental Hygiene.
Is marked other than "natural", or liems '

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat

Baltimore, Maryland 21215-0036

Direct

Funeral

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Completed

Be

10e. Street and Number

12th

11. Marital Status

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The law requires that the death certificate be executed

or Attending Physician:

the

Division of Vital Records, P.O. Box 68760,

Examiner attending physician and for use as the burial-transit ed by the detached page Be After this c Certification: To within 24 hours after deam.
To the Funerel Director: /

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23a. Part 1. Enter the disease, or	complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line.	Approximate Interval Between Onset and Deatl
Immediate Cause (Final disease or condition resulting in death)	a. Intracerebral Hemorrhage Due to (or as a consequence of):	9 days
Esquentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ue to # r as a consequence of):	entroun
resulting in death) Last	Due to (or as a consequence of): d.	

ician/Medical Physi þ Completed

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 Yes 2 No

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 4☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

2004

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

Day

24a. Was an autopsy perform 1 Yes 28 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner'

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Yeer) 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1🗡 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

RES-000 8-140 Batimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Chris Mi Horl, 600 N Wolfe Street, Mer Chris Mittone,

State Registrar

Medical

31. Date filed (Month, Day, Year) 1 2004



			1 - For State Registrar	State of Mary	and /		artmeni tificate			and M		gienę Reg. Nd:	Z 11 11 14	13308
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42 P	27 is r trau		Charles Peter		nđ		1000	nt Drive				
s lar	Importent: If item 27 any Injury or other tr. once.		20a. Method of Disposition		20b. Pła		sition (Name of natory or other place		Date		n - City or Tov	
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paritification Pages Department of	oorte / Inju		21. Signature of Funeral Service	Licensee	meu.		Name and Addres	4.5				l Home, Inc
a 88	any ir		D. Scott	· 1come	moder		147 Duke			_		MD 21401
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	it caused the death.							Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition		HSpira	Tien	MARI	monia				Onset and Death
	edical- ıminer		resulting in death)	Due t	to (or a a conseque	ence of):	-					1
LAU		_	Sequentially list conditions,	b	to for as a consecue	anno offi						
pet	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	<	o for as a constant	arica osp						
, axecu	al-tra	хаг	that initiated events resulting in death) Last	cDue t	to (or as a conseque	ence of):						
ate be ex	physician and the burial-transit	dical E		d								
tificat	g phy as th	ledi										
h cen	attending ph d for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregnance birth 2 - Fetal o		Ectopic pregnancy				Date of deliver	•
о два	ed by the attendir detached for use	sicie	in the past 12 months?		gnant at time of dea		Other (specify)			1	Month [Day Year
at the	d by the	Phy	9 Unknown									
The law requires that the death certificate be executed	pg eq		Part II. Other significant condition	ns contributing to	death but not result	ting in the un	iderlying cause give	en in Part I.	23e. Did to	_/		e cause of death?
9	s been s	Completed							24a. Was		o. Were autop	sy findings available
The	ite ha	mo								rmed?	death?	pletion of cause of
	rtifica ctor, p	BeC	25. Was case referred to medical					26. Place of Deatl				
Physician:	direc	일	examiner?	Hospital: 1 /	Inpatient 2 E	R/Outpatient	3 □ DOA Othe	ar: 4 🗆 Nursing Ho	me 5 Resid	lence 6 🗆 C	other (Specify)	
- Bu	fter thunera		27. Man or of Death 1 Natural 5 Pendin		te of Injury onth, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe h	ow injury occ	urred	
tendi Jeath.	tor: A	cati	2 Accident investig	gation not be				Yes 2 □No				
or At	Direc in by	Certification:	4 Homicide determ	ined 288. Pla	ce of Injury - At hom Iding, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tox		nber or Rural	Route Number,
pital	filled		29a. Certifier 1 ☐ Certifyin	ng Physician: To 1	he best of my know	ledge death	occurred at the tim	ne date and place	and due to the	cause(s) and r	manner as sta	ted
To the Hospital or Attending within 24 hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical one)	Examiner: On the	basis of examination	on and/or inv	estigation, in my op	pinion, death occurr	ed at the time,	date and place	e, and due to t	the cause(s)
To th	To the	Me	29b. Signature and title of certifier	0/	1		29c. License	number		29d. Date sign	ged (Month, D	ay, Year)
			1 NLS	WINN	Wen n	20	1)3	8445		03/	23/0	4
			30. Name and address of person	who completed ca	use of death (Item	23a) (Type, I	Ridach	1 AVE	Ann	a pel	i m	ソ
:	Sta Registr	-	31. Date filed (Month Par Year)		Ra istrar's Signatu	ire .		Y	· / · / · · · ·	7	-	
	Healan	CII		4	The second secon							1

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** 19, March 2004 8:35 PM Truman Howard Peters /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard 15700 Bushy Park Road Woodbine If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X** M 2□ F 467-12-8845 92 Director 21,1911 Aug. Minnesota Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic event, the Medical Exercicer must be notified at 1 Yes 2 No Director Maryland Howard Woodbine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15700 Bushy Park Road or items 23a 21797 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel; or ite 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Home Improvement 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hermann August Peters Sophie Bartak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Southwood Avenue Silver Spring, Maryland 20901 Fred Peters/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 22, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or W. Arundel Crematory 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly X. Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition bladder (ancer **Physician** resulting in death) /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a t be detached f ☐Yes 2☐No 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ♠ No certificate 2 ☐ No 1 🗌 Yes Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.

To the Funstal Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification; To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home S Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Duc53709 ann MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buwie KAJ 3066 mitchellville C Hotal LA 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State MAR 23 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 State Registrar 04/07/04, T.M., Kent Co. Certificate of Death Amended #8 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Dey} 2004 **Physician** Gilbert Joseph Quasney April 3, 9:20a. /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**∑**M 2□F 217-30-2991 Director 68 Maryland Usual Residence of Decedent 08/19/1935 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f shov the Medical Examinat must be rediffed at 1 ☐ Yes 2 → No Maryland Oueen Anne's Chestertown Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Warwick Road 21620 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 G Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) Carpenter carpentry 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd 2 should be fi th and Mental H 27 is marked of traumatic ever Michael Quasney Edna Lulie Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other trau Dorothy Quasney /Wife 203 Warwick Road, Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 04/07/2004 Hurlock Cemetery Hurlock, Maryland Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 21. Signature of Funeral Service Licensee once. bren fellows Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pulmonary Emboli 20 min. /Medical Due to (or as a consequence of) Examiner Hypercoagulability of malignancy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed Metastatic Adeno Carcinoma Unknown Primary ng physician ar resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9□ Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Acute MI 4/1/04: HV Acuto CVA 4/1/04; 1 Yes 2 No 3 Probably 4 Inknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has t rector, page 2 s autopsy performed? 1 ☐ Yes Division of Vital 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ို 1 Yes 2 No (his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Hospitel or Attending Physician: 1.24 hours after death.

• Funerel Director: A pletely filled in by the for within 2

To the complete

Neil Stoddard, M.D., 100 Brown Street, Chestertown, MD 21620

THE WOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 0 6 2004 State Registrar

(Check only

29b. Signature and title of certified

32. Redistrar's Signature

5

29c. License number

D50996

29d. Date signed (Month, Day, Year)

04

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registra 13312 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Roland Eugene Ricker, Sr. April 2004 11:57 A^M /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1)☑M 2□F 214-16-0748 81 Director 02/16/1923 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County d other than "natural", or iteme 23a or 28a-f show event, the Mudical Examiner must be nutified at 10d. Inside City Limits Washington Hagerstown 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 17956 Garden Lane, Apt. 2 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ģ White 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk Truck Driver Freight 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry (unk) Ricker Bessie (unk) Dagenhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Pages 1 and 2. Health a item 27 le Teresa E. Fiddler/Daughter 254 Blair Street, Martinsburg, WV 25401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If eny injury or once. Cedar Lawn Mem. Gdn. 04/14/2004 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses Sm 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician FAILLIRE (ESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUHOMA Samuelitally list and tions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached PH! 9☐ Unknown 9 Unknown à s been signed by should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. STAGE REMOUNICIN Hemolial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown HEVERICRUSIO WABRIES ME CUTIC; 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? 6 DETRETTER this certificate 1 ☐ Yes 2X No or Attending Physician: ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 🗌 Inpatient ö 2 X ER/Outpatient 3 DOA funeral 27 Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 ⊠Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12931 Oak Hill Avenue, Hagerstown, MD 21742 31. Date filed (Month, Par) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 07, Myra M. Ringer 10: 25P M APRIL 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAGERSTOWN WASHINGTON RAVENWOOD LUTHERAN VILLAGE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month Day, Year) April 13,1914 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number **Funeral** 1 □ M 2 🗓 F 89 214-14-6543 Yrs Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at Hagerstown 1 ☐ Yes 2 X No Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21740 10903 Knotty Pine Dr. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Specify Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Waitress 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked otherny injury or other traumatic event Be Claudia M. Morris Arthur L. Mowbray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 N. Shelby St. Hobart, IN. 46342 Richard Ringer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State April 9, 1 Burial 2 Cremation 3 Removal from State
4 Denation 5 Other (Specify) Smithsburg Crematory Smithsburg, Md. 2004 21 Signature of Funeral Service Licens 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** Attrus clarite /Medical Due to (or as a consequence of). **Examiner** ngestion Dajlune Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? (es 22 No certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2

death certificate be executed o Records, Vital of

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division

To the Hospital or Attending within 24 hours after To the Funeral Direct

State

this

After t

Director: filled in by the

death.

Certification:

Medicai

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

EUR

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

368

1 ☐ Yes 2 ☐ No

29d. Date signed (Month. Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of seeth (Item 23a) (Type, Print)

28d. Describe how injury occurred

31. Date filed (Month Pay.

5 Pending investigation

6 Could not be determined

27. Magner of Death

Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 | Homicide

(Check only one)

32. Degistrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene o Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** Catherine G. Ridenour March 2004 5:38 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington County

9. Birthplace (State or Foreign County) Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 200 Months 89 220-09-7172 Director July 18, 1914 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 10a. State 10b. County 1 Yes 2 No Director Maryland Washington **Hagerstown** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a 23a or 2 201 Pangborn Blvd. 21740 U.S.A. Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after deament of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or items ury or other traumatic event, the Medical Examinating. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 <u> Aircraft Manufacture</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Keiffer Roy Spessard ٥ Sally Maude Spessard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 20b. Place of Disposition (Name of cemetery, crematory or other place)

1745 Edg wood Hill Circle, Apt. 204 Hagerstown, 20c. Location - City or Town, State Beverly A. Nichols/Daughter 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory | Mar. 10,04 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 reucho 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner physicien and s the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medicai as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? ģ Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 100 3 ☐ Probably 4 ☐ Unknown as been si Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? (es 2 2 No page certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After s after de. -- Director: Afte 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours at To the Funerel D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check on 29b. Signatu 29d. Date signed (Month, Day, Year, 30. Name death (Item 23a) (Type, Print) who completed 32. Registrar's Signature State and Registrar

Charles Edward Rohrer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-01833 State of Maryland / Department of Health and Mental Hygienes RPD Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1220 P M March 13, 2004 Charles Edward Rohrer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 17907 Oak Ridge Drive Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 67 Yrs. Director 217-32-2644 3,1936 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examinar must be notified at Maryland 1 XYes 2 No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Apt. 101 N. or Iteme 23a U.S.A. 14. Race - Americen Indian, Black, White, etc. Funeral 11 W. Baltimore St. 21740 Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 □ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) Owner Overhead Door Co. 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any jury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arnold Ray Rohrer Doris L. Long Sprecher 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorcas J. Rohrer/Wife 11 W. Baltimore St. Apt. 101 N. Hagerstown, MD 2174 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Greenlawn Mem. Park Mar. 17, 04 Williamsport, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Samature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 Luc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf disease or condition resulting in death) utra oras **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2√2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No 24a. Was an page 1X Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA At Scene 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Subject shot self Formed 3/13/04 Found 1100 M 1 ☐ Yes 2 XNo investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Mother's RASI'VENCE 17907 Oak

within 24 hours after death. To the Funeral Director: A filled in by Hospital To the

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

111 Penn Street, Baltimore, Maryland 21201 ZABILICAH 32. Aggistrar's Signature

and manner stated

'YX,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) March 14, 2004

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** Irene Elizabeth ROLLINS March 13, 2004 11:40 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Oay, Year, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 99 July 6, Illinois Director 326-18-3557 1904 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Show 17 is marked other then "naturel", or items 23e or 28e-f show treumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Maryland Washington Boonsboro Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19307 Manor Church Road 21713 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Item any injury or other treumatic event, the Mentallian once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: à white 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lega1 secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William G. Hensel Martha E. Umbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Rollins - son 19307 Manor Church Rd., Boonsboro, Md. 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Greenwood 3/20/04 Chicago, Illinois 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME tred L. Vestal 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION DAYS /Medical Due to (or as a consequence of) Examiner ATRIAL FIBRILLATION UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed the attending physician and hed for use as the burial-transit ADRIC STENOSIS YEMIS that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical ATHRO SCLEROSIS IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š JAUNDICE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peeu CHOLE DOCHO LITHIASIC 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performe SENILITY certificate of or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pendina investigation 1 TYes 2 No filled in by the fu 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospitel o within 24 hours af To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c License number 29d. Date signed (Month, Day, Year) 29b. Signatute and title of certifier 12/2 March 14, 2004 044996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOONSBORD MD 21713. LAPPANS RA MALIK MD 20311 ZAFAL 32. Redistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 🍎 🗍 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 4, 2004 Year 8:55 PM treeman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner alisbury Nursing and Rehab Center Salisbury, Wicomico Md. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 12 F Director 237-23-3985 Yrs. MD Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itema 23a or 28e-f show other treumatic event, its Mudical Examinar must be notified at 10d. Inside City Limits Director 1 Nes 2 No Jorces md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 S. Churc 304 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 110 Baltimore, Maryland 21215-0036 Whit 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 Is in any injury or other treum <u>once.</u> matthew Reeley Show Hill 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Femation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 4-6-04 21. Signature of Funeral Service . N me and Address of Facility Bennie Smith +/H917 W. Isabella St Schisbury 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a eon. /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☑ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne Death 28b. Time of After 1 Certification: 28d. Describe how injury occurred 1 atural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William SWS MID 1346 S. Division St. Suite, Salisbury, Md. 21804 32. Hedistrar's Skin ture State Registrar

REEMAN, CYNTHIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** WHITE APRIL RATHEL 8, 2004 'a 4:15 م /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 29450 Waller Road Wicomico Delmar If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🛣 F Yrs. Director 75 251-30-9154 May 27,1928 South Carolina Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show in then "neturel", or Iteme 23e or 28e-1 show the Madical Examinar must be notified at 1 ☐ Yes 2 🛣 No Director Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29450 Waller Road 21875 death v USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after all Hygiene. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 🔀 No Specify: ₽ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Banks Market 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 Is marked oth eny injury or other treumetic event QDE8. Harry A. White Elizabeth Julia Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Birge/son 29450 Waller Rd., Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4/12/04 Springhill Memory Gardens * 4 ☐ Donation 5 ☐ Other (Specify) Hebron, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association poures 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Micinoma 9 **Physician** un /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit be executed signed by the attending physician and d be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □Yes 2 □ No 3 □ Probably 4 □Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate 2 1 NO 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ ₩6 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Watural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident al or Attend after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel o within 24 hours aff To the Funerel Di 29a. Certifier 1 🖵 eartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10 Da

Division of Vital Records. P.O. Box 68760

State Registrar APR 1 3 2004

dneu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WENRICH

1340 S. D.

32. Registrar's Signature

gnature & sports

153 84

SALISBURY

21804

MD

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Day Y*e*ar **Physician** EDRIE EUNICE RICE APRIL 11 2004 /Medical 4:00 PM 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Mary's Hospital Leonardtown St Mary's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2Q,F Yrs. Director 579-14-2393 85 3, 1918 Maryland Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours aftar death with the Maryland Dapartment of Haaith and Mantal Hygiane. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 😾 No **Funeral Directo** Maryland St Mary's Mechanics ville 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 26956 North Sandgates Road 20659 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3√2 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hostess Food 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edgar Yates Euna Haswell Yates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara J. Waybright (daughter) 26300 Morganza Turner Rd. Mechanicsville, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dofation 5 ☐ Other (Specify) Charles Memorial Gardens 4-14-04 Leonardtown, MD 22. Name and Address of Facility 21. Signal re of Faneral Service Licensee M00173 Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Iviedical Immediate Cause (Final disease or condition resulting in death) Sepsis **Examiner** Due to (or as a consequence of): Examiner by the attanding physician and tached for usa as the burial-transit To the Hospital or Attanding Physician: Tha law requiras that the daath certificate ba axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown signed I Ŕ cata has been siç , paga 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed cartificata has 1_ Yes 2 000 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Other: 4 Nursing Home Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours eftar death.

To the Funerel Director: After this completaly fillad in by tha funeral dir Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifier Cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kange (Q 30. Name and address of person who complet a cause of death (Item 23e) (Type, Print) Daniel Alexander, M.D. 25500 Point Lookout Rd Leonardtown, MD 20650

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

APR 15

32. Raistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 13320 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RICCKERT **Physician** 8.30AM 16 MARY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5710 Beach Haven Road Dorchester East New Market 8. Date of Birth (Month, Day, Year) Feb. 16,1927 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F South Carolina 723-14-6625 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location rai', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Dorchester East New Market 10e. Street and Number 10g. Citizen of What Country? USA 5710 Beach Haven Road 21631 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: al Hygiene. 3 other than "natural", c ivant, the Medical Exar þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professional Artist Self-Employed 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 1s marked othe sny injury or other traumatic avant, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Augustus Talbot Gertrude Roberts 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter W. Rieckert, M.D./Husband 5710 BeachHaven Road, East New Market, MD 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State East New Market Cem. 3/21/2004 East New Market, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 East New Market, Maryland 21631 Lonar 3a. In 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FEW DAYS EREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): **Examiner** IT ZMORRHAGE. FEW MONTHS EREBLAL Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran attending physician and Due to (or as a consequence of): Physician/Medicai the as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Demonce 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D15165 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M. J. 105 AURUNA ST. CAMBRIDGE MA SHARLEE MAHMOOD 31. Date filed (Month, DaMAR 1 9 State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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			Decedent's Name (First, Middle, L.	ast)				-	2. Date	e of Death	Day	Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4	lb. City, Town, or	Location of I	Death		4c. County		th
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	Funeral			Sex 7. Age 1	(In yrs. last birti		If Under 1 Year Months Days	If Under 24 Hours	Min. (Mo.	e of Birth nth, Day, Y			thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		78				MAK	. 3,	1926	JA	PAN
	yland		10a. State 10b. County		10c. City, Town	or Locat	tion						10d. Inside City Limits
	a-f st	ctor	MD CARROLL		SYKESV	/ILLE							1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number				10f. Zip Code			100	. Citizen of	What Co	ountry?
	death with the Maryland ms 23e or 28a-f show roust be notified at	ra	7200 THIRD AVE.				21784				JSA		
-0030	77 hours after death with the Marylan "natural", or Items 23e or 28e-f show calcul Examiner coust be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			as Decedent of Hi es, specify Cuba	ispanic Origin n, Mexican, F Specify:	n? (Specify Ye Puerto Rican, e	s or No- etc.)		ck, Whit	erican Indian, te, etc. ASIAN
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Maryland		o Be	YOSHISABURO TAS						JE NISH			,0,	
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Ē	Pages nent of int: If it		1 ☐ Burial 2 【A Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				CREMATO		/16/20	04 S	TEVENS	VIL	LE, MD
Baitimore,	permit. Pages Department of t Importent: If ite eny injury or of		21. Signature of Funeral Service Lice	12 / Enbein	N		lame and Addres LOWS, HI SHAMRO					RAL 619	HOME, P.A.
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	/Medical		resulting in death)	Due to (or as a	consequence		7,7,		() 5)		-		
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ğ	death certifi e attending I id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		3 🗆 Ea	ctopic pregnancy				23d. Da		
		sicia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐ Pregnant at t			other (specify)				Mo	onth	Day Year
r Ö	at the	Phy	9 Unknown						00	Did taba			the series of death?
Ś	The law requires that the de ite has been signed by the a bage 2 should be detached	ρ	Part II. Other significant conditions	contributing to death but	t not resulting in	the unde	erlying cause give	en in Part I.	236		2 🗆 No		the cause of death?
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S E	sicien: The law certificate has t irector, page 2 s	Completed					1		248	 Was an autopsy performe 		were au prior to d death?	utopsy findings available completion of cause of
	n: Th ficate r. pag	e Co	25. Was case referred to medical					00 81		Yes 2		1 🗌 Yes	2 5 No
VItal	Physicien: r this certific ral director,	o Be	examiner?	Hospital: 1 ☐ Inpatien	nt 2 🗆 ER/Out	tnationt	3□ DOA Othe		f Death (Check ing Home 5 [no 6 Doth	or (Saa	oife)
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DIVISION	or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, far . (Specify)	rm, street	t, factory, office			ation (Stre or Town,		er or Ru	ural Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	Medical C		Physician: To the best of aminer: On the basis of and manner stat	examination and								
	vithin o the	Me	29b. Signature and title of certifier	101			29c. License	number		290	. Date signe	d (Mont	h, Day, Year)
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			30. Name and address of person who								-	-	
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	Sta Registi		31. Date filed (Month, Davi)	6 2004 ^{32. Registration}	r's Signature	K A	poste						

Catherine

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** April 8, Mary Lois SINGHASS 2004 2:13 a.m. /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death **Examiner** Julia Manor Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 2, 1912 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🖾 F 215-28-1656 Yrs 91 Virginia Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11 W. Baltimore Street 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Completed by Specify: 3 X Widowed 4 Divorced Year or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 homemaker her own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Samuel Bates Rose Ada Inskip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Singhass - son 11 W.Baltimore St., #1102, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4/10/04 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cemetery Ellicott City, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner Granis a es the buriel-transit Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician end for use es the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of desth? To the Hospital or Attending Physician: The law requires thet the within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by I completely filled in by the funeral director, page 2 should be detect 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1L Yes 2LING 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Medical Certification: To 1 Yes 2 No 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1-Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) DO060396 0 30. Name and eddress of person who completed ceuse of death (Item 23e) (Type, Print) D MUNSHER 32 Registrar's Signature 31. Dete filed (More State

Registrar

		•	For Amend Item #5 State of Maryland 1- State Registrar SH/WCHD 4/19/04 per FH	d / Depa <i>Cer</i>	irtment of He tificate of D	alth and M eath		iene200L	13324
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	Robert Lee Settles		45 City Taylor and	tin- of Dooth	April	6, 2004	
	Examin	er	4a. Facility Name (If not institution, give street and number) 12 South Walnut Towers Apt. 21	14	4b. City, Town, or Le	rstown		4c. County of Dea	
	Funeral				If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Ri	rthplace (State or Foreign country)
	Director		5. Social Security Number 6. Sex 7. Age (In yrs. II. Am 2 F 57	Yrs.	Months Days	Hours Mill.	(Month, Day, Aug. 5,	1946 Ma	ryland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Loc	cation			<u> </u>	10d. Inside City Limits
	Mary I sh	tor	Md. Washington		Hager	stown			1 X Yes 2 ☐ No
	th the	Jirec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	ountry?
	s 23a	rai	12 South Walnut Towers Apt. 214			1740		U.S.A	
20	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene item 27 is marked other than "natural", or flems 23s or 28s-1 show other traumatic event, its Micdical Exeminer must be multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	Vas Decedent of Hisp Yes, specify Cuban, □ Yes 2\\ No	Sanic Origin? (Spe Mexican, Puerto I Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
5	2 hours		15. Decedent's Education	16a. Deced	ent's Usual Occupation	on		16b. Kind of Business	
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<u>a</u>	uld be Menta arked atic ex	To B	Robert E. Settles			Vir	gil J. I	Wachtel	
ש	2 sho		19a. Informant's Name/Relationship (Type, Print)		-			City or Town, State,	
ב ני	1 and Health em 27		V. Josephine Settles (Mother) 20a. Method of Disposition 20b. Pt		OLG GEOT; sition (Name of natory or other place)	, D	ato	hsburg, Md. 20c. Location - City of	
2	Pages ent of ht: If it		I M Bullat 2 Cremation 3 henioval from State	_	natory or other place) Cemetery		9,	Funkstown	
Dallinor	permit. Pages Department of I Important: If ite ony injury or of		21. Signiture A Funeral Service Licenses	22.	. Name and Address	of Facility	12525 B:	radbury Av	e.
В			23a. Part1. Enter the disease, or complications that caused the death						Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	BLE	HECA	70 m	+		Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequ	uence of):					100 (3)035
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Ď	an and	Exa	resulting in death) Last Due to (or as a consequ	uence of):					
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O. DOX	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
ŗ	s that the hold by details	by Ph	Part II. Other significant conditions contributing to death but not resu	ulting in the un	iderlying cause given	in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
cords,	en sig	ed b	DIABETES MALLITU	21			1 □ Ye	s 2□No 3□P	robably 4 Authknown
2000	The law requires that the death certifi ate has been signed by the attending age 2 should be detached for use as	Completed					24a. Was a autops perform	y prior to ned? death?	utopsy findings available completion of cause of
2	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?			6. Place of Death	(Check only on	9)	
5	Physic this co	7	1	ER/Outpatient	3 DOA Other:	4 Nursing Hon		nce 6 Other (Spe	ecity)
SICI	ding th. th. After funer	tion	1 €Natural 5 ☐ Pending 2 ☐ Accident investigation	Injury	28c. Injury at Work? M 1 ☐ Yes	s 2 □No	8a. Describe no	w injury occurred	
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At how building, etc. (Specify)	me, farm, stre	eet, factory, office	2	28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,
	Hospite 24 hours Funeral stely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the time, estigation, in my opin	date and place, a lion, death occurre	and due to the ca	tuse(s) and manner a ate and place, and due	s stated. a to the cause(s)
	within To the	Me	29b. Signature and title of certifier		29c. License n			9d. Date signed (Moni	
			- TENE MO		D (80	7(9		APRILE.	2004
2+	1-2		30. Name and address of person who completed cause of death (Item VASANT DATTAMO 3 W	is m	14457	HAG	ERSTO	WN MO	21740
	Sta Registr		31. Date filed (Month) Part Year) 9 2004 32. Projector's Signat	ture B. Ap	ali				

Division of Vital Records, P.O. Box 68760,

	•	1 - Stete Registrar	,	Cer	tificate of	Death	Re	g. No.	
Dhuniain		1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medica		FRANCES RUTH SI	GLER				April	6. 2004	6:48 P ^M
Examine		4a. Facility Name (If not institution, give WASHINGTON COUNTY			4b. City, Town, o	r Location of Death HAGERSTO	٧N	4c. County of Dea	ath ASHINGTON
Funeral Director		5. Social Security Number 6. Se 214-54-0212	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth SEPT ^{h, Day}	(ear) 1911 9. Bi	rthplace (State or Foreign Ounting MARYLAND
pu *		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loc	ration				10d. Inside City Limits
Aaryla sho	ö	,	NGTON	, 101111 51 250		ONSBORO			1 XYes 2 □ No
28a-	Director	10e. Street and Number	NOION		10f. Zip Code	- CINDIDOINO	10	g. Citizen of What C	country?
after death with the Marylan or Itams 23a or 28a-f show infrections! be notified at		141 S. MAIN STREE	T.		100.20	21713			J.S.A.
death ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. W	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No-	14. Race - Am	erican Indian,
2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. is marked other than "natural", or llams 23a or 28e-f show aumatic event, the Wedeal Exeminer mat be notified at	۾	1 ☐ Never Married 2 ☐ Married 3 ☐ Mividowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Yes 2 XNo	Specify:	Hican, etc.)	Specify:	ver, etc.
72 hc	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Decede	ent's Usual Occup	ation during most of work	ing 16	6b. Kind of Business	s/Industry
within ne. han.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	emaker		Own	n Home
filed v Hygie ther t		17. Father's Name (First, Middle, Last)	<u></u>		110/110		e (First, Middle, Ma		1 110/110
ould be Mental warkad o	To Be	CHARLES HUBERT HU				MARY A	ANNA KAUF	FMAN	
and ealth n 27		19a. Informant's Name/Relationship (T) MARGARET L. ITNYR	E, DAUGHTER	110	DELLA LA	ANE, BOONS	SBORO, MA	City or Town, State, ARYLAND 2	Zip Code) 21713
Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	metery, crem	sition (Name of atory or other place	(e)		Oc. Location - City or	
t. Pa rtmen rtant: njury		'4 □Doration 5 □ Other (Specify)			CEMETER				MARYLAND
Departit Departit Import any inj		21. Sign fure of Fu eral Service Licens	Paul M. De		Name and Addres	ERAL HOME		d Nationa oro, Maryl	
		23a. Pag 1. Enter the disease or comp	lications that caused the death.						Approximate
Physician		Immediate Cause (Final	ne cause on each line.	1		1-1	1 4		Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a consequence	ence of):	myocar	seal in	fareleon	,	manuly
Examiner		Conventially list appairings	h		0	V			
D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					-
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	- 0					
be executed sician and burial-transit			Due to (or as a conseque	ence or).					
entificate the ding physics as the b	Medicai		d						
n certif		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan	icy				23d. Date of de	liven
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	by Physician	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3□E	Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
at the de by the a	hys	9 ☐ Unknown	9□ Unknown				-		
es thai	b b	Part II. Other significant conditions co	ntributing to death but not resul	ting in the und	derlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
w require been si should I		conquiling	heart for	ileure			1 🗆 Yes	2 12 No 3 □ P	robably 4 Unknown
e lawr has be	Completed		<i>\</i>				24a. Was an autopsy	24b. Were ar	utopsy findings available completion of cause of
	် ပ						performe 1 ☐ Yes 2	ed? death?	2 □ No
ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death	(Check only one)		
Phys this ral dir	9	1 Yes 2 No	1 Inpatient 2/1E	R/Outpatient 28b. Time of		4 CHANGING FIO	me 5 Residence 28d. Describe how	ce 6 Other (Spe	ecify)
ding th. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 □	(? Yes 2 □ No	EGG. DOGGNDG NOW	injury occurred	
Atten r deal sctor. by the	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	ne, farm, stre			28f. Location (Stree	et and Number or Ri	ural Route Number,
s afte	Certification:	4 Homicide determined	building, etc. (Specify)				City or Town,	State)	
	Medicai (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
To th To th comp	Me	29b. Signature and title of certifier			29c. License	number	29d	I. Date signed (Mont	h, Day, Year)
		My I			D32	518	41	2/04	
44	1	30. Name and address of person who co			rint)		- 1/	-/-/	
55			et 21 Wyand Dri		eedysvill	le, Maryla	and 21756	/ 301-43	32-2222
Stat Registra		31. Date filed (Month PR), 188 20	32. Registrar's Signatu	. Spa	ute				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

dore Le	е :	5nreve 1 - ^{For} state Unpend Item#23 Registrar	State of l a-b,27,28a-	Varyland / f, Per Me, G	Depart 830-47	ment of 28/04ee ficate of	Health and Death	Mental H	lygien Reg. No	2004	13326
Physici	an	Decedent's Name (First, Middle, L.	•					2. Date of Month	Da	y Yeer	3. Time of Death
/Medic		Theodore Lee Shr						April		2004	1721 p ^M
Examin	er	4a. Facility Name (If not institution, gi		er)	4	-	or Location of De	eath	40	County of Deeth	
				Age (In yrs. last bi	irthdau) I	W L L L L C	msport	rs 0 Data of l	Dieth.	Washingt	
Funeral Director		521-39-6021 Usual Residence of Decedent	1X M 2 F	35		Months Day		in. (Month,	Day, Year	968 Flor	place (State or Foreign ntry) i da
ow ow		10a. State 10b. County		10c. City, Tov	vn or Locat	ion				1	Od. Inside City Limits
the Mary 28a-f eh	ector	Maryland Washing	gton	Willi	.	ort 10f. Zip Code			10- 0	**	1X Yes 2 □ No
ath with 23a or	Funeral Director	36 West Salisbury	· · · · · · · · · · · · · · · · · · ·			217	95			tizen of What Cour	ntry ?
ours after der rel', or Items Execulments	by	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	^{s?} _{No} 1990−	If Ye	s Decedent of es, specify Cu Yes 2 X No	Hispanic Origin? ban, Mexican, Pu o Specify:	(Specify Yes or lerto Rican, etc.)	No-	14. Race - Americ Black, White, Specify: Whit	etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or Items 23e or 28e-f ehow any injury or other traumatic event, the Medical Execution must be nutified at once.	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12) 12		or 5+)	(Give kını	NOT use retir	during most of w	vorking	Win	ind of Business/Ind dow Parts nufacture	s
uld be file lental Hyg 'ked othe ilc event,	To Be C	17. Father's Name (First, Middle, Las Larry Paul Shrev						_{lame (First, Midd} en Jane			
shou and M mar		19a. Informant's Name/Relationship		198	b. Mailing A	Address (Stree	at and Number or	Rural Route Nun	ber, City	or Town, State, Zip	Code)
and 2		Bennie J. Shreve	Wife	3	6 Wes	t Sali	sbury St	Willi	amspo	ort,MD 21	795
of He of He fitem roth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [Bamayal from Sta	20b. Place o	of Dispositionry, cremate	on (Name of ory or other pi	ace)	Date	20c. L	ocation - City or To	wn, State
Pag ment ant: I		'4 □Donation 5 □ Other (Spec		Smith.	sburg	Crema	tory 04-	08-2004	Smi	thsbu r g,M	laryland
permit. Departimport any inj		21. Signature of Funeral School	2/							al Home,P liamsport	A. ,MD 21795
Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Cardia	o ine. C Arrhythni as e consequence	ia	he mode of dy	ing, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a consequence	of):						
nd	Examiner	Cause (Disease or injury that initiated events	c					<u>. </u>			
cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or	as a consequence	of):						
tificat ng phy as th	•										
at the death certific by the attending p tached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death		topic pregnant her (specify)	Э			23d. Date of delive Month	ry Day Year
The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions	contributing to death	n but not resulting i	n the under	rlying cause g	ven in Part I.		tobacco u	use contribute to th	. /
The law reate has be page 2 sho	Completed							24a. Wa aut per 1 1 4 Yes	opsy formed?	prior to com	osy findings available appletion of cause of
icien: Th certificate rector, pag	0	25. Was case referred to medical					26. Place of D	eath (Check only		1 TYES	2 No
nysici nis cer	ToB	examiner? 1 XYes 2 No	Hospital: 1 _ Inpa	itient 2 ER/Ou	utpatient 3	3 DOA O	has	1		6 Other (Specify	at scene
itending Ph death. tor: After th the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		Day Year)	Time of Injury d 5:15			28d. Describe			, de boeile
r Atte	tific	3 ☐ Suicide 6 🔀 Could not to determined	28e. Place of	Injury - At home, fa				28f. Location City or To	(Street an	d Number or Rural	Route Number,
To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical Cer	(Check only 2 XMedical Exe	found at nysicien: To the be miner: On the basis	t home st of my knowledge of examination an	e, death occ	curred at the t	me, date and plac	36 W. Sa	lisbur	y St., Wil	liansport, MD ated. the cause(s)
ithin 2 the or the	Med	29b. Signature and title of certifier /	and manner	Stated.			se number			e signed (Month, D	
U U		Mayne ?	nella	ele ou	y	oc				il 4, 200	

MDRYDRIM 31. Date filed (Month, Par, Year) 2004 111 Penn Street, Baltimore, Maryland 21201

State Registrar

Registrar

Bellia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 4:35 Jack Layton SHACKELFORD narc 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) April 18,1918 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 10XM 2□ F 217-10-2584 85 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits works item 27 is markad other than "natural", or Itama 23a or 28a-f abov other traumatic event, the Modical Examiner marke notified at 1 ☐ Yes 217 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17613 Homewood Road 21740 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Ital 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced WW II white 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) assistant cuperintendent city water 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Shackelford Fannie Mongan ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia H. Shackelford - wife 17613 Homewood Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ŏ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 3/17/04 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumana /Medical Due to (or as a consequence of): Examiner alnul -21 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) the attending physician Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 25No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Certification: To 1 Tyes 2 ER/Outpatient 3 DOA Sidi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ To the Hospital within 24 hours a within 24 hours To the Funeral Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Money

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 15

altimore, Maryland 21215-0036

Box 68760.

o

Records,

Division of Vital

sex

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year William Ernest Schmidt 3:20 P M March 11 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney-Keedy Home & Village Boonsboro Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 MM 2 ☐ F 088-10-2126 84 Director June 14,1919 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event, if a Medical Ever; instrmust be notified at once. Washington Maryland Hagerstown 1 XYes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18020 Sand Wedge Drive 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Serves 2 No 194. If Yes, Give Year or Dates: 1946 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1943-Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Management Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Schmidt Wilhelmine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V.June Schmidt/Wife 18020 Sand Wedge Drive Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

■Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Mar. 15, 2004 | Hagerstown, Maryland 21. Signature of Juneral Service nsee 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part1. Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LIVER DISEASE Physician EWD STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL DISTASTE END STAGR 53 ustillly late incitions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atter 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Cther (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate Vital 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 15 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ₩Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03/12/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalid M. Waseem, M.D. 1126 Opal Court Hagerstown, MD 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

3.20pm

March 11, 2004

WILBUR IRA SPRECHER JR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiener	0	01.	1	
Certificate of Death Reg. No. C	. 0	U4	- 1	4

		1 - For State Registrar	Otate of Mic		Ce	rtificate of	Deat	h		eg. No.) 4	13330
Physi	ician	Decedent's Name (First, Middle, Last,							2. Date of Deal Month	Day	Yeer	3. Time of Death
/Med	dical	Wilbur Ira S 4a. Facility Name (If not institution, give		Jr.		4b. City, Town, o	or Location	o of Death	MARCH	7, 2004		0300 A M
Exam	niner	ROUTE# 68 @ 632				DOWNSV		I OI Dealli		WASHIN		V
Funera	al	Social Security Number 6. Sec.	x 7. Age	(in yrs. last b	irthday)	If Under 1 Year Months Days	If Und	er 24 Hrs. Min.	8. Date of Birth (Month, Day)			lace (State or Foreign try)
Directo		214-90-0000	XM 2□ F	35	Yrs.	Months Days	Hours	IVIII.	May 29,	1968	Mar	y land
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	ocation					10	0d. Inside City Limits
Maryl f sho	ō	Maryland Washing	aton			Willia	ameno	r+				1 ☐ Yes 2√XNo
r 28a	Directo	10e. Street and Number	91011			10f. Zip Code	шэрс	1 1	1	0g. Citizen of Wi	nat Coun	try?
th with	a D	16615 Kendle Roa	ad				2179	5			USA	
tems	Funeral		12. Was Decedent E Armed Forces? 1 ☐ Yes 277N	ver in U.S.	13.	Was Decedent of H If Yes, specify Cub	lispanic (an, Mexic	origin? (Sp an, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- America White, 6	
rs afte	by Fi	1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 277N If Yes, Give Year or Dates:	0		1 □ Yes XX No	Specif	y:		Specify:	la!	hite
2 hou	ted t	15. Decedent's Edu	cation	16	a. Dece	dent's Usual Occup	ation		_	16b. Kind of Bus		
Pin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5-	+)	(Give life.	kind of work done DO NOT use retire	during m d)	ost of work	ing			,
d with serification of the	E OC	12		·′	Apı	prentice	Plum	ber		Plu	mbin	g
If E, INITY FIGURE 2 12 13-0030 Is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination must be notified at	Be	17. Father's Name (First, Middle, Last)							e (First, Middle, I)	
y ic	2	Wilbur Ira Spre	echer, Sr.		b 44-101		-	inda		auffman		(1977 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
d 2 sl d 2 sl th an th an traur						ng Address <i>(Street</i> 5 Kendle						21795
THeal		Bethany Sprecher - 20a. Method of Disposition	- wire			sition (Name of matory or other pla		The lander in		20c. Location - C		
Deficiency Demit. Pages Department of Important: If It Iny injury or o		1 🖾 Burial 2 □ Cremation 3 □ P 1 4 □ Ponation 5 □ Other (Specify)		1		Mem. Par	- 1	Mar 1	2 2004 1	lilliame	nort	,Maryland
permit. Pages Department of Himportant: if Ite	ouce.	21 Signature of Funeral Service License	90	3,1470,1614,160		Name and Addre				TITIOMS	POLI	100
D 8855	a	Date Du				25 S. Con				lliamsp	ort.	21795 Marvland
		232 Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each lin	the deeth. Do	not ent	er the mode of dyli	ng, such a	is cardiac o	or respiratory arre	est,		Approximate Interval Between
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Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be delached for use as the burial-transit		IF FEMALE:	0 - 16									
aath c attenc for us	Physiclan/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 □ Fetal deat		Ectopic pregnancy	/			23d. Date Monti		ry Day Year
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w requires that the death cer been signed by the attendir should be detached for use	by Pt	Part II. Other significant conditions con	tributing to death bu	t not resulting	in the u	nderlying cause giv	en in Par	: I.	23e. Did tob	acco use contrib	ute to the	e cause of death?
quires an sig									1 □ Ye	s 252No 3	☐ Proba	abiy 4 Unknown
law re	Completed								24a. Was ar autops	24b. We	ere autop	sy findings available
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sician: The law scertificate has birector, page 2 s	Be (25. Was case referred to medical examiner?				1 - 1		e of Death	(Check only one			
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s after so a line of in the	Certification:	4 Homicide	building, etc.	(Specify)	ad				Potomae St	eet and Nymber State) Koud Hagers	ers foun	wars.
ospit houn unere		29a. Certifier (Check only (C	sicien: To the best of	f my knowledg	e, death	occurred at the tir	ne, date a	ind place, a	and due to the ca	use(s) and mann	er as sta	ited.
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical	one)	and manner stat	ed.	nwor in			rain Occurr				
To To	Σ	29b. Signature and title of certifier	10	11		29c. Licens			29	d. Date signed (MARCH	Month, D	
4		W VV	~ X /		-							
H		30. Name and address of person who co				^{Print)} n Street,	. Ral	timor	e. Mary	land 212	01	
	tate	31. Date filed (Month) Ray Year)	32. Registra			/ /	,		, imiry.		<u>.</u>	

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Vear **Physician** Scare be rough APRIL 2004 2150 NORMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANCHORAGE NURSING & REHAB. CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 10XM 2□F JUNE 8, GEORGIA 85 Director 219-07-7771 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ahow item 27 is marked other than "natural", or items 23a or 28a-f abov other traumatic avent, the Medical Examinar must be molfied at 1 X Yes 2 No Directo DELAWARE SUSSEX LAUREL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19956 USA 11262 SUSSEX HIGHWAY by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SHIPPING & RECEIVING CLERK MANUFACTURING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be f and Mental b h and Mental SCARBOROUGH ANNIE PEARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun <u>once.</u> BOBBY SCARBOROUGH/SON 424 LINCOLN AVE., BELLMAWR, NEW JERSEY Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) NEW HOPE CEMETERY 4/7/04 WILLARDS, MARYLAND 21. Signatur of Fineral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Tasi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO MY OPATTHY 5 years /Medical Due to (or as a consequence of): **Examiner** 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death ed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: 1 Natural 5 Pending al or Attendin after death. I Director: Aft d in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who Walm 0051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIVISION ST SALISBURY 1415 · S 21504 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

APR 0 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13332 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 12 March 12:25 PM Myron Lindbergh Stenger 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hagerstown Washington County Hospital Washington 8. Date of Birth (Month Day Year OCT 7, 1927 Birthplace (State or Foreign Country)
 Mary land 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Months Days Min Hours 1**X**XM 2□ F 76 Director 219-14-9961 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? *natural", or items 23a 21795 USA 10709 North Oak Tree Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces?

VMVes 2 \(\text{No} \) No 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1945a filed within 72 hours after I Hygiene. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: If Yes, Give Year or Dates: Specify. δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Driver Milk Delivery 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth ery injury or other treumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) Be Stenger Margie May Hawbaker Christman Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10709 N. Oak Tree Circle Williamsport, Maryland 21795 Evelyn L. Stenger - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park Mar. 16, 2004 Williamsport, Maryland 22. Name and Address of Facility
Osborne Funeral Home, P.A. 21. Signature of uneval Service Licen 1/6pm 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. En in the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician AJ es disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit ned by the attending physician and detached for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 2 🗆 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 No Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 →No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospitel or Attending 4 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours To the Funeral 1 🕒 Certifying Physician: To the best of pry knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 9 29b. Signature a nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tol 0 30. e and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 2 11 11 11 For State Registra Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** March 26, 2004 Carl William Strawberry, Sr. 1:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 834 Coxswain Way Annapolis Anne Arundel If Under 1 Year | It Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 12–13–1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 579-52-6747 80 Pennsylvania Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö or Items 23a 834 Coxswain Way 21401 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 [XYes 2 □ No If Yes, Give Year or Dates: 1946–47 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 5+ years Dentist Dental other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tem 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Strawberry Elizabeth Saltrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia A. Strawberry/ Wife 834 Coxswain Way, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Kalas Crematory 3-27-04 Edgewater, MD 21. Signatural funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER COLON /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disactor injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ØNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 24No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifie (Check only one) and manner stated 29b. Signature and title of certified מטגו 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21401 BESTERIE NO STANLET

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2004

State of Maryland / Department of Health and Mental Hygiene 2 () () [13334 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death ^{Day} 2004 **Physician** Herbert Dirk Sartori March 23, 10:00 a.^M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1198 Summit Drive Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Yrs. Director 064-16-7335 83 1920 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f shov ir than "natural", or Items 23a or 28a-f shorthe Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1198 Summit Drive 21401 United States Funerai filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Host/Management Hospitality 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ... Pages 1 and 2 should be fit timent of Health and Mental H tant: If item 27 is marked ot Herbert Sartori Emma Jean Kimma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1198 Summit Drive Annapolis, Maryland 21401 Ellen S. Drummond (Daughter) 20b. Place of Disposition (Name of Chesageake Cremation Center March 25, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Stevensville, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Adams Funeral & Memorial Care 21. Signature of (n. r. Service Licensee M00982 814 Bestgate Rd. Annapolis, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LND /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medicai as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 4 Unknown Completed 1 Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No certificate 1 Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 No Certification: To 1 🗌 Yes 4 Nursing Home 5 XResidence 6 □Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Morth, Day, Year) 29b. Signature and le of certifier 36. Name and add 31. Date filed (Month, Day, Year) State 2004 Registrar

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п	Funeral Director		5. Social Security N	H	ZIM 2 TE	ge (<i>in yr</i> s. ii 24	ast birthday) Yrs.	If Under Months	Days	Hours	Min.	Month, Da	ay, Year)	9.1	Birthplace (State or Country)	Foreign
100			220-06- Usual Residence o			24				J		2-2	3-80)	MD	
	nylan how		10a. State	10b. County		,	, Town or Lo	cation							10d. Inside City	
	88-fs	cto	Md.	Worcest	er	Ве	erlin								Yes	2 No
	th with the 23a or 2	Funeral Director	10e. Street and Nu 312 N	. Main S	Street			10f. Zip	811				10g. Cit	USA	Country?	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It was 12 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Exeminer man be notified at	by Funer	11. Marital Status 1 Never Marr 3 Widowed	ried 2 Married 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Deced f Yes, spec 1 ☐ Yes		Ispanic Origi n, Mexican, Specify:	n? (Spec Puerto Ri	fy Yes or No can, etc.)	0-	14. Race - A Black, W Specify: Wh		
9	2 hou satura ical E	ted		15. Decedent's Ed	ucation		16a. Dece	dent's Usua	al Occupa	ation	,		16b. K	ind of Busine		
21215-0036	12 should be filed within 7 n and Mental Hygiene. Fis marked other than "n raumatic event, the Med	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	5+)		trac		during most o	of working)	Bu	uildir	no	
	il Hyg other	Be C		(First, Middle, Last)						18. Mother	s Name (First, Middle			.9	
/lar	uld by Menta Nrked rrked	To E	Denni	s E. Smi	th					Mel	issa	Меу	ers			
Maryland	and la ma	, y	_	ame/Relationship (T								Route Numb	er, City o	or Town, State	, Zip Code)	
	1 and 2 Health tem 27 i		Dennis 20a. Method of Dis		. Fath					Stre	et Dai			Md.,		_
Baltimore,	8 2 = 5		1. Ø Burial 2	position ☐ Cremation 3 ☐ I 5 ☐ Other (Specify)	Removal from State	' L	ace of Dispo metery, cren gree:			i	4-15			lin,	or Town, State	
Balt	permit. Pa Departmen Important: any injury once.		21. Signature of Fu	eral Service Licen	\$68,					s of Facility Funer	a1 H	Iome	Ber	lin,	Md.	
			23a. Part1. Enter t shock, or hea	the disease, or comp art failure. List only of	lications that cause one cause on each I	d the death.	. Do not ent	er the mod	e of dying	g, such as ca	ardiac or i	espiratory a	rrest,		Approximate Interval Between	een
	Physician		Immediate Cause disease or condition	(Final on	a LETAD AV	10 ME	EK In	AURIO	SIN	1) Con	PRE	SSIDW	ASP	HIXID	Onset and De	eath
	/Medical Examiner		resulting in death)		Due to (or as											
	3 3K	Jer	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	enditions, nmediate	b. Due to (or as	a consequ	ence of):									
	nd nd transit	ami	that initiated events	5	c											
50,	icate be executed physician and s the burial-transit	edical Examiner	resulting in death)	Last	Due to (or as	a consequ	ence of):									
68760,	cate t	dica			d										-	
P.O. Box 6	ath certif ittending or use as	by Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2[9 Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pr Other <i>(sp</i>					2	23d. Date of o	leliv <i>er</i> y Day Ye	ear .
	uires that the de signed by the a Id be detached t		Part II. Other signit	ficant conditions co	entributing to death b	out not resul	lting in the ur	nderlying ca	ause give	en in Part I.			obacco u Yes 2	/	to the cause of dea	
Records,	ne law requir has been si ge 2 should	Completed									_	24a. Was autor		24b. Were prior to	autopsy findings av o completion of cau	allable use of
Vital	ician: Th certificate rector, pag		25. Was case refer	red to medical						26 Place of	f Dooth	Heryes Check onl	2 No		es 2□ No	
>	Physician: r this certifica ral director, I	To Be	examiner?		Hospital: 1 ☐ Inpatie	ent 2XE	R/Outpatien	t 3 🗆 DO	A Othe	r				3 □Other (S	pecify)	
n of	ding Physician: The h. After this certificate h: funeral director, page		27. Manner of Deat	h 5 Pending	28a. Date of Inju	JIV :	28b. Time of Injury		8c. Injury Work						LANDED OF	MIH
Sio	eath. or: Al	catic	2 Accident	investigation	4-11-0	4	12:17 1	М	1 🗆 Y	es 2 No					ul overtur	
Division	or Att	Certification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In- building, et			et, factory	, office		281	f. Location (S City or Tox	Street and vn. State,	d Number or	Rural Route Numbe	er.
	pital curs a eral (29a. Certifier	1 Codifying Phy	rsician: To the best	AW Oz		- Coourad	at the tim	o data and					KUY UDELE	STEPL
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only one)	2 Medical Exam		of examination										
	To the vithin To the comple	Me	29b. Signature and	title of certifier	1			29c	. License	number			29d. Date	e signed (Mo	nth, Day, Year)	
			DX) (10)	Winto. D	melkell) W	n			0.0	C.M.E		Apr:	il 11,	2004	
	91		30. Name and addr	ess of person who c	ompleted cause of c	death (Item										
	C.7		MARYDA	1700 A	KOREL					reet,	Balt	imore	, Mai	ryland	21201	
	Sta Registr	_	31. Date filed (Mon	APR 13 2	004 32. Hagisti	rar's Signatu	the A	nade	F							

State of Maryland / Department of Health and Mental Hygiene? () () [3] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Charles MARCH 26 /Medical 2004 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ba blimor Johns Hopkins The Hospita If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F West Virginia 74 Nov. Director 215-24-7786 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Howard Ellicott City 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a 8380 Sunset Drive 21043 United States Completed by Funeral 14. Race - American Indian, Black, White, etc. or itema 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 Nd 952-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates: 1954 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) it. Pages 1 and 2 should be filed withi riment of Health and Mental Hygiene. rtant: If itam 27 is marked other than 8 Truck Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Shiflett Ruby V. Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Shiflett/Wife 8380 Sunset Drive Ellicott City, MD 21043 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) injury or Metro Cremetory 3-26-2004 Catonsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc permit. 21. Sonat ite of Funeral Zelvice Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Prevmonia Immediate Cause (Final **Physician** disease or condition resulting in death) 5 days /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ρ Day Month Year 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Fenal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been Colitis Colostridium Dificile Colitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28c. Injury at Work? 28b. Time of al or Attending P 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funaral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier RES-000 March 26 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Balpmore, Maryland 21287 Stein North Wolfe Street Brady Stein
31. Date flied (Month, Day, Year) 32 Aegistrar's Signature State MAR 26 Registrar 2004

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Alovsius Smith Thomas 2004 8:35 pm /Medical April 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Chester River Manor</u> Chestertown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F 77 Director Oct.24,1926 206-14-3253 <u>Pennsylvania</u> with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show id other than "natural", or items 23e or 28e-f shovevent, it a Medical Examinar must be notified at 1 Yes 2 No Director MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 8518 Broadneck Road USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: If item 27 is marked other then "naturel", or ite Afried Foldes:

1 Gyes 2 No
If Yes, Give
Year or Dates: 1950-51 1 Never Married 2 Married
3 Widowed 4 Divorced 1 ☐ Yes 2 🕱 No Specify: Specify: δ white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 George Smith Margaret McCormick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 8518 Broadneck Road Chestertown, MD 21620 Margaret Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Cntr. 4/7/04 Stevensville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Fellows, Helfenbein, & Newnam Funeral Home PA Kuko 130 Speer Rd. Chestertown, MD. 21620 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Levels vo Vascular Accident 14 davp disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician hysician/Medical as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed ğ ANGUITIS 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: OH Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title



2

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

29c. License number

D 50996

29d. Date signed (Month, Day, Year)

4/5/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Yeer March Joseph TOMIC 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Hagerstown

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Feb. 21) Washington County Hospital Washington Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**∑**M 2□ F Yrs. Director 84 Feb. 090-09-5958 Yugoslavia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in then "natural", or items 23a or 28a-f ehor the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11430 Englewood Road 21740 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give ↓ Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: W.W. II Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Police Officer County Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event 900.8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Unknown Mary Schlienz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candace Kline - Daughter 11430 Englewood Road Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 3/13/04 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home ROU 415 E. Wilson Blvd. Hagerstown, Md. 21740 23 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any reading to minorate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 □ Yes 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 Yes 2 1 No 2□ No 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 2 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ceptiler 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

5

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

The set and

22911 Jesserson

3 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cantone

31. Date filed (Month, Day, Year)

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3/12/04

Southsburg . marylano

State of Maryland / Department of Health and Mental Hygien 👂 🕦 🛴 13339 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Flora T. Townsend APRIL 2004 1300 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROOVANI Medical S44/361/14 YENINSVIA HICAMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □ F 214-30-8827 Director 69 April 16,1934 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28e-f show 10d Inside City Limits other treumstic event, the Medical Examiner must be natified at Director MD Wicomico 1 ☐ Yes 2 → No Salisbury 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 5 7587 Kowen Avenue 21801 or Items 23e U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No. Specify: Black 3 XWidowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) 12 should be filed wi h and Mental Hygien 7 Is marked other th 4 Food Packaging Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Porter M. Deale ဂ္ဂ Ruby S. Dashiell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Important: If item 27 Is any injury or other treuonce. Deshera C. Hitch, daughter 6104 Rockawalkin Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Green Acres Mem Park 4/10/2004 Salisbury, MD 21. Signature of Funeral S. Vice L. 1599 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** A SCU D disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit MELLITUS DIABETES that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9□ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔟 Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide n 24 hours aft ne Funerel Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 10 29d. Date signed (Month, Day, Year) 4/6/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babulal Das 106 Milford ST. #504B Salisbury 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 8 2004

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 20**0**4 8:30 Pm **Physician** Margaret Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Millennium@South River Edgewater If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1 ☐ M 2 💯 F 1925 Jan. 26 New Jersey 79 Director 577-36-0354 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director <u>Maryland Prince George's</u> Bowie the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23s or 20776 USA 3400 Morlock Lane death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after begarment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or liter any injury or other traumatic avant, the Medical Examinet once. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2√⊋No Baltimore, Maryland 21215-0036 Specify: Specify: **Black** Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None 12th None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Bailey Isabel Goode 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Kinch (Niece) 5524 Belmar Terrace Phila. Pa. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial ②☐Cremation 3 ☐Removal from State 3/29/04 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zavry B. Fosse Mou483 Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 214 shock, or heart failure. List only one cause on each line. 21 401 Approximate Interval Between Onset and Death Immediate Cause (Final emoltia **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed IWILLO use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Dhknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? res 2**X** No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending Injury Natural 1 ☐ Yes 2 No death. investigation the f 2 ☐ Accident hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signati e and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, State Registrar

10011

		State Registrar 1. Decedent's Name (First, Middle, Last)			rtificate of	Dealii	2. Date of De	_	V	3. Time of Death
sicia edica		Herman M. Turi	ner				Mar.	27,		7:47 p
mine	-	4a. Facility Name (If not institution, give s 478 Louise Lat			4b. City, Town,	or Location of Dea Arnold	th		County of Deeth	rundel
ıl r		5. Social Security Number 6. Sex 216-28-8246		s. last birthday) Yrs.	If Under 1 Year Months Days			rth ay, Year) 29, 1	9. Birth Cou	place (State or Foreigntry)
		Usual Residence of Decedent 10a. State 10b. County MD Anne Ar		City, Town or Lo	ocation Arno	old				10d. Inside City Limit
	Funeral Director	10e. Street and Number 478 Louise Lane			10f. Zip Code	1012		10g. Citiz	en of What Cou USA	-
	p	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (: ban, Mexican, Pue o Specify:	Specify Yes or N no Rican, etc.)		4. Race - Ameri Black, White, Specify:	
	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occi kind of work done DO NOT use retir	during most of we	orking	16b. Kin	d of Business/Ir	ndustry
	dwa	Elementary/Secondary (0-12)	College (1-4or 5+) \$\Delta\$			Engineer			Westing	house
-	To Be C	17. Father's Name (First, Middle, Last) Charles Herman T	urner			Cather	ine (First, Middle ine Galc	nis		
		19a. Informant's Name/Relationship (Ty Lois Turner/Wife				Lane, Ar				p Code)
		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, cre	osition (Name of matory or other pi Cemeter	4101	1, 2004		ation - City or T ltimore	
		21. Signature of Fineral Service Licens	as sone		2. Name and Add Barranco 195 Gov.	& Sons, Ritchie	P.A. Sev Hwy, Sev	erna erna	Park Fu Park, M	neral Hom D 21146
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the de ne cause on each line.	ath. Do not er	iter the mode of dy	ring, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	1	Immediate vause (Final disease or condition resulting in death)	Due to (or as a cons	equence of):						
l	4	Sequentially list conditions.	HBF	2						
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Obsease or injury that initiated events	Due to (or as a cons	equence of):						
	dicai Examine	that initiated events resulting in death) Last	Due to (or as a cons	equence of):						
The second secon	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	□Ectopic pregnar □ Other (specify)	ю	*****	2	3d. Date of delik	very Day Year
	þ	Part II. Other significant conditions co	ntributing to death but not r	esulting in the	underlying cause (given in Part I.		tobacco us		the cause of death?
	Completed						24a. Wa auto per 1 □ Yes	s an opsy formed? 2 No	24b. Were aul prior to co death? 1 \(\sum \) Yes	opsy findings availab ompletion of cause of
	Be	25. Was case referred to medical examiner?	Hospital:		17	Neb a m	eath Check on			
	1: To	1 ☐ Yes 2 💢 No 27. Manner of Death	28a, Date of Injury	ER/Outpatie	ent 3L DOA	4 Nursing	Home 5 Res		Other (Spec	ify)
	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year) 28e. Place of Injury - A	t home, farm, s	M 1	Yes 2 No	28f. Location	(Street and	d Number or Ru	ral Route Number,
	Certi	4 Homicide	building, etc. (Spe							-ttd
	edical	29a. Certifier (Check only one) 1 Certifying Phy Medical Exem	vsician: To the best of my liner: On the basis of exam and manner stated.	ination and/or	ath occurred at the investigation, in m	opinion, death oc	ce, and due to th curred at the time	e cause(s) e, date and	place, and due	to the cause(s)
	Me	29b. Signature and title of certifier	2	>		nse number D 28 08	6	29d. Date	signed (Month	, Day, Year)
		30. Name and address of person who o	completed cause of death (I	tem 23a) (Type	e, Print) Av	nold 1	ND . 7	2101	Z Victor	Plazner MD
	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	1					

			For	State of Maryland / Department		•	
			1 - State Registrar	Cei	rtificate of Death	Reg. N	ło.
н	Physici	an	Decedent's Name (First, Middle, Last)	0 +1	1 1 1 1 max	2. Date of Death Month March 2	3. Time of Death 2 0 0 4 1 : 0 5 PM
	/Media	cal	4a. Facility Name (If not institution, give s		OMAS 4b. City, Town, or Location of Death	1	1 2004 1:05 PM
1	Examir	ner		lare - The Pines	Easton		Talbot
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		×18-16-8080	M 2007 86 Yrs.	Monta Bays Hours Mill.	Sept. 11,1	917 Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
\circ	Mary P-f sh	tor	MD Talho	+ Rell	evue		1 ☐ Yes 2 ☐ No
8	th the	Direc	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
5	ath w	ral	5680 Ga	te Street	21662		USA
9	Itams	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	1 □ Yes 2 127No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.
99	ursaf	by	3 12 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itams 23e or 28e-f show ita Medical Examiner musi ke notified at	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade	ation 16a. Dece completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ding 16b.	Kind of Business/Industry
121	within lene. than the	mp	Elementary/Secondary (0-12)	College (1-4or 5+)			200-1-1-1-1-1
	filed y	ပိ	17. Father's Name (First, Middle, Last)	1,400	uction-Line W	e (First, Middle, Maide	
an	ould be Mental arked o	To Be	William	White	Etta	Serina	Bentley
Maryland	2 should and Men is marke	Γ.	19a. Informant's Name/Relationship (Type		ng Address (Street and Number or Rur		or Town, State, Zip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28e-f show or other traumatic event. The Medical Examiner must be rediffed at		Deloves S	a SSer 32 L	Ynnbrook Cou	Date = 20c.	ON, MD. 21601
Baltimore,	Pages 1 nent of H int: If its		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	matory`or other place)		Location - City or Town, State
Εij			4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License				ston Maryland
Ba	permit. Departm Importe any inju		Danolle C	· Sources !	2. Name and Address of Facility TENRY FUNERAL 10 Washinigton	HOME, P. A	ida e. MD. 2/6/3
			23a. Party. Enter the disease, or complice shock or heart failure. List only on	cations that caused the death. Do not enter cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	probable acus	Le carriage	en es not	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1 . /	1 1	- 111101
	2.701111101	-e	Sequentially list conditions, if any leading to immediate	Due to (or as a consequence of):	2 CANDIAVASCU	IM dis	ease yeary
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
oʻ	e exection and an arrial-tr		resulting in death) Last	Due to (or as a consequence of):			
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		·			
89 X	certific ding p	Physician/Medl	IF FEMALE:	3c. If yes, outcome of pregnancy			23d. Date of delivery
Box	death a atten d for u	ician	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 €	Ectopic pregnancy Other (specify)		Month Day Year
P.O.	that the de ned by the a detached f	hys	9 Unknown	9□ Unknown			4.4
	signed d	by P	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?
of Vital Records,	w require been si should I	Completed by	17/ Per 7 7 137 2	n CEPA			No 3 Probably 4 ☐Unknown
3ec	sician: The law certificate has b irector, page 2 s	mple	Diabetes M.	1/1/fur		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a	n: Th ficate or, pag	e Co	25. Was case referred to medical	rpple	OO Bloom of Broad	1 Yes 2 N	
Ş	Physician: r this certificatal director,	To Be	examiner?	ospital:	0.1	h (Check only one) ome 5 Residence	6 □Other (Specify)
J of	ding Phys h. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time or Injury		28d. Describe how inj	
Sio	andin eath. or: Af	catlo	2 Accident investigation	, , , , , , , , , , , , , , , , , , , ,	M 1 Yes 2 No		
Division	I or Attandi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Phys	ician: To the best of my knowledge, deatl	n occurred at the time, date and place.	and due to the cause(s) and manner as stated.
	To tha Hospital within 24 hours a To tha Funaral I completely filled	Medical	(Check only 2 Medical Examination)	er: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date ar	nd place, and due to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	PA	29c. License number	29d. D	Pate signed (Month, Day, Year)
,			P ROL	1	125750	3	120/04
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, 200 100 100 100 100 100 100 100 100 100	NILD AVENUE	1-ASTON	MS 21601
	Sta	ate	31. Date filed (Month, MARea 2 4	004 32. Redistrar's Signature	houles	- 5,0	
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Etta Thomas

State of Maryland / Department of Health and Mental Hygiene [] [] For State Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** March 21, 2004 3:45P M John Roger Todd /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester 6036 Shiloh Camp Road Hurlock 9. Birthplece (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 8,1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 XM 2□ F 81 Yrs. 199-03-9309 Director Usual Residence of Decedent death with the Maryland 10a. State 10d, Inside City Limits 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Madical Examiner must be nutified at 1 ☐ Yes 2 No Director Maryland Dorchester East New Market 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 21631 USA or Items 23a 3615 Green Point Road Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 □ No 1943— If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ White 3 XWidowed 4 ☐ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Shop Foreman Truck Transport permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If item 27 is marked other thany injury or other traumatic event, Impore. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jessie James Todd Nicie Spear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Todd, Sr./Son 6036 Shiloh Camp Road, Hurlock, Maryland 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 3/24/2004 East New Market, MD East New Market Cem. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lightsee Zeller Funeral Home, P. O. Box 207, 106 Main Street, East New Market, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 min resulting in death) /Medical Due to (or as a consequence of): **Examiner** LUNC 2 whis ANCEZ el S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq ce of): Examiner berosclerosis The law requires that the death certificate be executed burial-transit enerical and Due to (or as a conseque of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown δ signed I Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes ≥ 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 50 N/s House Certification: To 1 ☐ Yes 2 ☑ No this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours To the Funeral 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies D26388 Le M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 302 Colling Ave Her lock Med. 21643 MichA 32. Registrar's Signature 31 Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200 L 13344 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 15^{Day} **Physician** March 10:55 p.M Virginia Taylor 2004 Naneita /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chesapeake Woods Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Dey, Year) June 29, 1917 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 274 F 214-07-7689 86 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or itams 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Cambridge MD Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2906 Sloop Road 21613 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□ Yes 2⊠ No Specify: Specify: white à 3 ☐ Widowed 4 Ø Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) advertising representative newspaper 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Louis Eliza Mae Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Health a Boneita Abbott daughter 2906 Sloop Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Pages
Department of I Importent: If Its
any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) 3/16/04 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 Shin K. But 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 50 dun disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner mence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine vascular accident The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? res 2 No 1 Yes 1 ☐ Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P this After this 28c. fnjury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturaf Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 140059973 husen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Brzmbie St Cambridge MD 21613 Johnson atrici 31. Date filed (Month, Day, Year) State en & Sporte Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13345 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** Month Year 12:05 P M 11, Tomas Santiago Tormo April /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, July 25 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**☐M 2☐F Director 577-66-5700 62 Yrs. Argentina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Madical Examiner must be nutified at 1 ☐ Yes 2 ☐ No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 15101 Interlachen Drive Apt. 719 20906 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 ☐ No Specify: þ ^{Specify}₩hite 3 Widowed 4 Divorced Argentine Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmen Ginestar Tomas Tormo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tree once. 15101 Interlachen Dr. #719 Silver Spring, MD 20906 Cristina E. Tormo / wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 13, 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory Odenton, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility MO1251 Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21029 Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) a. Glioblastoma Multiforme Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) hospice1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 ☐ Yes 2√ No 28b. Time of Injury 27. Manner of Death Certification: 28c Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Xiatural 1 Tes 2 No Director: 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 1 \(\) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \(\) Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ie M. D D09470 April 12, 2004

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State

Registrar

Box 68760

gistrar's Signature

10400 Connecticut Ave. Kensington, Maryland 20895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene P. Libre M.D.

APR 14 2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2004 13346 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** 12:15 AM vana 10 2004 00 inh /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20 Medical Cente Maryland none niversity I more 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. Months Hours M 2 F 216-29-6235 58 Director 12/31/1945 Vietnam Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 1 Yes 2 No Director Md. Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 3710 Joycin Court 21042 Vietnam Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Asian Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Floral 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Tuyen Trinh Them Tang ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Huoi Huynh/wife 3710 Joycin Ct. Ellicott City Md. 21042 on (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State St. John's Cemetery 4/13/2004 | Ellicott City, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. note 4112 Old Columbia Pike Ellicott City, Md. 21043 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4-6 weeks **Physician** Due to (or as a confequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Observe or tripury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed by the attending physician and ached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 No 1 ☐ Yes 2 No 1 Tyes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ဥ After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
2 Accident death. M 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier April 10 2004 MI 103 Name and address of per completed cause of death (Item 23a) (Type, Print) of 22 Baltimere MD 21201 Maryland Year) nivosity reame 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State 13 2004 Registrar

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of N	Maryland / De	oartment e <i>rtificate</i>			and M	ental Hy	giene Reg. No.	7 11 11 1	+ 1334	7
	Physici /Medio	al	1. Decedent's Name (First, Middle, La CLAUDETTE Tr	usty	-1	45 Cit.		I analian a	(D 11-	2. Date of De Month	02 ^{Day}	2004	0810 a	
	Examir	er	4a. Facility Name (If not institution, give Corsica Hill	Nursing	Center	Cen	tre	Ville	e		Qu		Anne's	
	Funeral Director		5. Social Security Number 218-48-5770 Usual Residence of Decedent	10 M 2/0 F	Age (In yrs. last birthda 56 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 12 2	$6 \frac{1}{9}$	9. 8	irthplace (State or Fore Country) MD	эign
	Aaryiand I show	ō	10a. State 10b. County MD KENT		10c. City, Town or								10d. Inside City Lin 1 ☐ Yes 2 ☒	_
	ath with the Marylan 23e or 28e-f show ust be multiked at	Director	10e. Street and Number		ROCK	10f. Zip	Code					en of What (Country?	
980	72 hours atter death with the Maryland natural', or Items 23e or 28e-f show digal Exa direct wat be incitified at	by Funerai	5662 Circle 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Park Dri 12. Was Deceder Amed Forces 1 □ Yes 2X if Yes, Give Year or Dates	nt Ever in U.S. 13 9?] No			spanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)				
Maryland 21215-0036	- 3	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 10th	ducation ade completed) College (1-4or	(Gi	edent's Usua ve kind of wor DO NOT us	k done d e retired)	uring most)	of working	ng		od of Busines	s/Industry Decker C	``
land 2	be tiled stal Hygi ed other event, I	To Be Co	17. Father's Name (First, Middle, Last James Wickes)	Tac	COLY	WOLI	18. Mother		(First, Middle,	, Maiden S		<u>Decker</u> C	<u>.O.</u>
Mary	d 2 should th and Men 7 Is marke treumetic		19a. Informant's Name/Relationship (-		nd Numbe	r or Rura	l Route Numb	er, City or		•	
Baltimore,	Pages 1 and nent of Healt snt: It item 2' ary or other		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Openation 5 Other (Special	Removal from Stat	e Capito	position (Name ematory or ot L Crer	ne of her place nato	ory 4	14/10/	2004	20c. Loc	etion City o	r Town, State)E	
Balti	Departm Departm Importer any inju		21. Synature of Funeral Service Lice	. Wade	WQ9026)	22. Name and Servi	Address	s of Facility $321\ V$	Ken √. S	neth t. An	Wall napo	ev Fu	neral MD 21401	
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8760,	icate be executed physician and s the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate the sequence of the cause (Disease or injury that initiated events resulting in death) Last	с.	s a consequence of): s a consequence of):									
P.O. Box 68	death certit e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetel death 3	□Ectopic pre					23	3d. Date of de Month	elivery Day Year	
	signed be de	by	Part II. Other significant conditions of	contributing to death	but not resulting in the	underlying ca	use give	n in Part I.	<u>.</u>	23e. Did to	/		robably 4 Unknow	
Division of Vital Records,	The ate ha	Completed								24a. Was autop perto 1 \(\text{Yes}	rmed?	24b. Were a prior to death?	utopsy findings availal completion of cause of s 2 \(\sum \) No	ble of
f Vita	Physicien: 1 r this certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	Hospital: 1 ☐ Inpat	ient 2 ER/Outpati	ent 3 DO	Othe	. 1	-	(Check only o	-/	 □Other (Spe	ecify)	
o uo	ding Ph h. After th funeral		27. Manner of Death 1. PNatural 5 Pending investigatio	28a. Date of In (Month, D	ury 28b. Time ay Year) Injury	of 28	Bc. Injury Work		2	8d. Describe h				
Divisi	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Ir	njury - At home, farm, s atc. (Specify)	treet, factory,			-	8f. Location (S City or Tox	Street and vn, State)	Number or R	ural Route Number,	
	he Hospitel n 24 hours a he Funerel I pletely filled	Medical C			t of my knowledge, de- of examination and/or stated.									
	To the within 2 To the complet	Σ	29b. Signature and title of certifier MMd S	un			License		1		29d. Date	6/04	th, Day, Year)	
			30. Name and address of person who David Smith 66		death (Item 23a) (Type Ch Hill F		.te	100	Ches	sterto	wn.	MD 2	1620	
à	Sta Registr		31. Date filed (Month, Day, Year) APR 0	32. Regis	Ar's Signature	Spore	رع							

			For State Registrar	State of	Maryland / [Department Certificate	of Health of Deat	n and Me th	ntal Hygie Reg.	ne2004	13348
~	D1 - 1111		1. Decedent's Name (First, Middle	e, Last)				2	Date of Death	Day Your	3. Time of Death
	Physici /Medi		Thelma Fi	rances	Tro	ester		l M	larch 10	Day 2004 Sear	4:50 A M
	Examir		4a. Facility Name (If not institution	•	ber)	4b. City,	Town, or Location			4c. County of Dea	ith
			Heron Point Nu				esterto			Kent	
	Funeral Director		5. Social Security Number 216-50-9682	6. Sex 7 1 □ M 2 □ F	. Age (In yrs. last birt	rhday) If Under Months Yrs.	Days Hour	s Min.	Date of Birth (Month, Day, Ye Ct. 25,	9. Bir 1915	thplace (State or Foreign ountry) Missouri
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Location					10d. Inside City Limits
	Mary 	ō	MD Prince	Georges	Fort	Washingt	-on				1 Tyes 2 □ No
	1 the	rec	10e. Street and Number	deorges	1 1020	10f. Zip			10g.	Citizen of What Co	ountry?
	23a o	a D	10917 Mariner	Drive			20744			USA	
	eep	Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U.S.	13. Was Deced	ent of Hispanic fy Cuban, Mexi	Origin? (Specif	y Yes or No-	14. Race - Ame Black, Whi	
98	or it	by F.	1 Never Married 2 Marr	If Yes, Give	21	1 ☐ Yes 2					Thite
Ö	hour:	q pe	3√3√Vidowed 4 □ Divorced 15. Deceden	Year or Dat		Decedent's Lieus	Ossuration		104		
21215-0036	within 72 hours after deeth with the Maryland ene. then "natural", or items 23e or 28e-f ehow he Medical Exambler maat be notified at	Completed	(Specify only highes	st grade completed)		Decedent's Usua (Give kind of won life. DO NOT us	k done during m e retired)	nost of working	160	. Kind of Business	/industry
212	y with	E	Elementary/Secondary (0-12)	College (1-	4or 5+)	Teacher				Educatio	n
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Maryland	should bents and Ments amarked	5	John Schwab]	Mabel M	ae Mast		
lan	and and is mu		19a. Informant's Name/Relations	hip (Type, Print)						ty or Town, State, .	
	s 1 and 2 should f Heelth and Mer item 27 is marke other traumatic		Jeffrey Troes	ter							wn, Md. 2162
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Ba	Depermine on impo		21. Signature of Funeral Service	Helfebe		Fellows 130 Spe	, Helfe er Road	nbein δ Cheste	Newnam	Funeral Md. 21620	Home, P.A.
н		1	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that can only one cause on ea	used the death. Do n ch line.	ot enter the mode	of dying, such	as cardiac or re	espiratory arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	_a END S	STAGE A	CZHEIN	NERS	DISEX	SE	>	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (o	r as a consequence of	of):)
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	utad I Insit	틑	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
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89)	artifica ing ph e as th		IF FEMALE:	1	entale _s A					100	
Вох	Tha law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	ome of pregnancy th 2 Fetal death	3 ☐Ectopic pre				23d. Date of del Month	ivery Day Year
o.	he de	ysic	1 ☐ Yes 2. ☐No 9 ☐ Unknown	4⊟Pregnai 9⊟Unknov	nt at time of death m	5 ☐ Other (spe	city)				,
O. O.	that the de led by the a detached		Part II. Other significant condition	ns contributing to dea	th but not resulting in	the underlying ca	use given in Pa	rt I.	23e. Did tobacc	o use contribute to	the cause of death?
Vital Records,	uires signe ild be	d by						1	1 ☐ Yes	20 No 3 □ Pr	obably 4 Unknown
Ö	w requir s been s should	ompleted						[24a. Was an	24b. Were au	itopsy findings available
Be	Tha la cate has page 2	E O							autopsy performed	prior to o	completion of cause of
		0	25. Was case referred to medical				26. Pla	ace of Death (C	1 Yes 2	No 1 ☐ Yes	2) A.No
	Physician: rthis certific ral director.	To B	examiner? 1 ☐ Yes 2∰No	Hospital: 1 ☐ Ing	patient 2 ☐ ER/Out	patient 3 DO	1			6 ☐Other (Spec	cify)
	ding Ph h. After th funeral		27. Manner of Death 1 SNatural 5 ☐ Pendin	28a. Date of (Month,	Injury 28b. Ti Day Year) In	ime of 28	c. Injury at Work?		. Describe how in		
Si	e : a	cati	2 Accident investig	ation		М	1 ☐ Yes 2				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 289. Place 0	f Injury · At home, far p. etc. (Specify)	m, streel, factory,	office	28f.	Location (Street City or Town, Sta		ıral Route Number,
	Hospital Hospital Hours a Funerai E	2	29a. Certifier	a Obveniena. To she b	ant of my knowledge	doothd	A Abratica data	and class and	due de de	()	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only 2 Medical i	g Physician: To the b Examiner: On the bas and manne	is of examination and	Vor investigation,	n my opinion, d	eath occurred a	at the time, date a	(s) and manner as ind place, and due	to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier			29c.	License numbe			Date signed (Monti	n, Day, Year)
	. > - 0		> ATLA	Much	mo		2004	158	/	3/10/2	004
			30. Name and address of person	who completed cause	of death (Item 23a) (Type, Print)				1	/
				Noble, M.		eer Road	Cheste	rtown,	Md. 2162	20	
1	Sta		31. Date filed (Month, Day, Year)	32. Reg	gis ar's Signature						
	Registr	ar	MAK.	2 2004	Marie D	Board	20				

			1 - For Stete Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of F rtificate of a	lealth and Death		ene2004	13349
			1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day V	3. Time of Death
	Physici /Medic		RACHAEL JOSEPHI	NE WAGNER				Apr 11	04 2004	1:30 p. ^M
ri .	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat	th	4c. County of Death	
1			REEDERS MEMORIAL H	IOME		ВО	ONSBORO		WASHIN	GTON
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Birth	place (State or Foreign ntry)
	Director		217-42-9789	M 2√2 F 90	Yrs.	THOMAIS Days	110010	APRIL 28.		ARYLAND
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	sho	ō			7,		OOMGDODO			1⊠Yes 2 □ No
	289-1	Director	MARYLAND WASHING 10e. Street and Number	TUN		10f. Zip Code	<u>OONSBORO</u>		. Citizen of What Cou	ntn/2
	with po a	ā		TD/ID			21 71 2			•
	eath	era	23 SCHOOLHOUSE COU	JKI 12. Was Decedent Ever in U	J.S. 13. 1	Was Decedent of H	21713 Ispanic Origin? (S	Specify Yes or No-	U.S.A	
36	be filed within 72 hours after death with the Maryland all Hygiene. And Hygiene. do ther then "netural", or items 23a or 28e-f show event, its Medical Exam net must be motified at	by Funeral	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give		fYes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puèr Specify:	to Rican, etc.)	Black, White, Specify:	etc.
21215-0036	hour tural		15. Decedent's Edu	Year or Dates:	16a, Dece	dent's Usual Occup	ation	16	b. Kind of Business/Ir	WHITE
15	n ne	Completed	(Specify only highest grade	ompleted)	(Give	kind of work done o DO NOT use retired	during most of wo	rking	D. ,	
212	with a second se	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		COOK			NURSING HO	OME
	e filed Il Hygi other vent,	0	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma		
Maryland	2 should be filed within and Mental Hygiene. is marked other then aumatic event, the Mental the Mental trains and trains and trains and trains and trains and trains and the Mental trains and trains	To B	LEMUEL HEZEKIAH CI	INE			LILLIE	VIRGINIA S	SPIELMAN	
ar	2 should and Menia smarker		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number or Ri	ural Route Number, C	ity or Town, State, Zip	Code)
	es 1 and 2 should b of Health and Ment f item 27 is marked r other traumatice		SHIRLEY W. LOWERY/				K LANE,		LE, MARYL	AND 21779
altimore,	of Ho		20a. Method of Disposition 1		Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)	Date 20	c. Location - City or To	own, State
<u>E</u>	Pag ment ant: jury c		* 4 □ Denation 5 □ Other (8pecify)	BO	ONSBOR	O CEMETER	X 4/07	7/2004 B	CONSHORO,	MARYLAND
Ball	permit. Pages 'Department of h Important: If ite eny injury or of		21. Signature of Funeral Service License	Paul M. D		. Name and Addres			National	
	⊕ □ ⊑ ⊕ □		Town 11 / Co	<i></i>					o, Marylan	
			23a. Part1. Enter the disease of compli shock, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arrest		Approximate Interval Between Onset and Death
100	Physician	É	Immediate Cause (Final disease or condition resulting in death)	Prenn	ania					(war
1	/Medical Examiner		resulting in dealth)	Due to (or as a consec	quence of):					
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):					
	uted d ansit	Examin	cause. Enter Underlying Cause Disease or injury that initiated events							
oʻ	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):					
68760,	ite be iysicik ne bu	dlcai		l,						
99	ng ph as th		IF FEMALE:							
Вох	death certific attending p	an/	23b. Was decedent pregnant	3c. If yes, outcome of pregn 1□Live birth 2□Feta		Ectopic pregnancy			23d. Date of deliver	ery Day Year
Ö.	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a:	Physiclan/M	in the past 12 months? 1 □ Yes 2 █ No 9 □ Unknown	4☐ Pregnant at time of o	death 5□	Other (specify)			Wichtin	Day real
P.0	hat thid by detac	P.	Part II. Other significant conditions con	stributing to death but not res	sulting in the u	aderlyina cause aiv	an in Part I	23e Did tohac	co use contribute to t	he cause of death?
Records,	uires that signed b	l by		se continue					2 □No 3 □ Prot	77.53
Ö	w requ	etec		enentis	· · · · · · · · · · · · · · · · · · ·			ik zasina		LIZELEN .
360	has has ge 2 s	Completed	- Aypertains					24a. Was an autopsy performed	prior to co	ppsy findings available mpletion of cause of
a	iician: The l certificate ha rector, page		as III					1 Yes 2		2 No
Vital	ysician: is certific director,	Be	25. Was case referred to medical examiner?	lospital:	1500	Othe		ath (Check only one)		
ō	Phys rthis raldi	5	27. Manner of Death	T Impatient 2	28b. Time of	1 3LI WA	4 CTRUISING I	28d. Describe how	e 6 Other (Specification of the following injury occurred)	у)
o	ding Phy th. : After thi funeral o	to	1 ☐ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Work M 1 🗀	k? Yes 2 ⊟No		,-,	
Division	or Attending after death. Director: After din by the funer	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory, office			t and Number or Rura	al Route Number,
	= = c	erti	4 Homicide	building, etc. (Special	fy)			City or Town, S	state)	
	To the Hospitel or Attenc within 24 hours after deatt To the Funeral Director: completely filled in by the	Medical C		sician: To the best of my knowner: On the basis of examina						
	thin 2 the or the	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	e number	29d.	Date signed (Month,	Day, Year)
	^		_ CONT.	ND		DIS			e (L 5, 2)	
	17		30. Name and address of person who co	moleted cause of doath (tra-	m 23a) /Tucc		-		-,	(
7	* 17		Dr. Zafar Malik 20				. rtn2+71	3/301-432-	-84/0	
	Sta	te	31. Date filed (Month, Day (Near)) 7		atura	naulis s	3 . WHIII	,	31,0	
	Registr		APR U 7 Z	104 Reven	1. 19	JALVA AV				

		-	For State	State	of Maryla		artment of H			ene2 () (g. No.) 4	13350
			1. Decedent's Name (First, Middle	Last)					2. Date of Death	1		3. Time of Death
	Physicia		TODD EUGENE	WITMER					March	4 -	co4	1327 PM
	/Medic Examin	_	4a. Facility Name (If not institution,		umber)		4b. City, Town, o	r Location of Death		4c. County o	f Death	
			WASHINGTON COU	NTY HOSPI	TAL			GERSTOWN			ASHIN	
	Funeral		5. Social Security Number	6. Sex 1 X M 2□ F	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,			ice (Stete or Foreign y)
	Director		165-58-9252		38	Yrs.			APRIL 3,	1965	PENNS	SYLVANIA
	and *=		Usual Residence of Decedent 10a, State 10b, County		10c. C	City, Town or Lo	ocation				10	d. Inside City Limits
	Marylan fahow led al	ō	MARYLAND WASH	INGTON			HAGEI	RSTOWN				1 ☐ Yes 2 No
	7 288	rec	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wi	hat Countr	y?
	death with the Maryland	a D	10420 BAILEY RO	AD			23	L740		U	.S.A.	
	e B B B B B B B B B B B B B B B B B B B	Funeral Director	11. Marital Status	12. Was Dec Armed F	cedent Ever in orces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No- p Rican, etc.)		 America White, et 	
0	or It	by Fu	1 Never Married 2 Marri	If Yes, G	2 □ No ive		1 ☐ Yes 2 🖾 No	Specify:		Specify:		
- - - -	tural'		3 ☐ Widowed 4 ☒ Divorced 15. Decedent	Year or	Dates:	16a Dece	dent's Usual Occup	ation	1	6b. Kind of Bus		HTE
<u>.</u>	in 72	piet	(Specify only highes	t grade completed		(Give	kind of work done DO NOT use retired	during most of wor	king			•
7	d with giene.	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+) 2		STUDE	NTTV		PUBLIC	C COL	LEGE
and	uld be filed within 72 hours after Mental Hygiene, arked other then "natural", or lie atic event, it a Medical Exaction	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle, M	laiden Sumame)	
<u>ya</u>	2 should be filed within 72 hours after death with the Maryla and Mental Hygiene and Mental Hygiene is marked other than "natural", or Items 23e or 28e-f ahov aumatic event, If a Medical Estriction must be notified at	2	NED ERVIN WITME						IE ZOLOT			7.00
<u>a</u>	l 2 sh and n is m		19a. Informant's Name/Relationsh		VIED.		ng Address <i>(Street</i>) BAILEY					21740
a,	ges 1 and 2 should t of Health and Men Il Itam 27 is marke or other traumatic		RONALD G. BEACH	LEY/PAKI		Place of Dispo	osition (Name of			Oc. Location - C		
وَ	permit. Pages Department of I Important: If its any injury or of once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Dogation 5 ☐ Other (S)			•	matory or other plac	1	/200/s T	3/ 3/3/TT T T	7 M(A)	DVI AND
	artme artme ortan injury		21. Sign ture of Puneral Service	1		OWN CEM	2. Name and Addre	ss of Facility	/2004 I 7606 01d	FOXVILLE Nation		
Ď	permit. Departr Imports any inji		1 an I May	Pau Pau	11 M. De	ean B	AST FUNER	RAL HOME	Boonsbor			
			23a. Part1. Enter the disease or shock, or heart failure. List	complications that	caused the de	ath. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arre	st,		Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition	1		الهجالا	- home	Mace			4	Onset and Death
	/Medical		resulting in death)	Due to	o (or as a conse		14:410	Mage			1	a P
	Examiner		Sequentially list conditions, if any, leading to immediate	b. Met	astah.	c live.	cana				×	norths
	pe psit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	equence or):						120 7
	xecut and al-trar	Examin	that initiated events resulting in death) Last	c. Due to	or as a conse	equence of):						genes
09/8	death certificate be executed e attending physician and od for use as the burial-transit	dicai E										
9	ifficati g phy as the	edi										
XOR	leath certific attending p	N/UE	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		□Ectopic pregnancy	,		23d. Date		
n n	ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify)			Mont	m L	Day Year
J.	requires that the de- reen signed by the a hould be detached f	Phy	9 ☐Unknown Part II. Other significant condition			aculting in the L	undoshiing oguso gu	ron in Part I	23a Did tob	acco use contrib	hute to the	cause of death?
Š,	26 PG	by	Harransum Harransum	and continuously to	GBAIT DULITOL II	esulting in the c	indenying cause giv	entilly act.			3 🗆 Proba	
Ö		etec	11940113001						24a. Was ar	24b W	ara autoni	sy findings available
Vital Records,	sician: The law certificate has b irector, page 2 si	Completed		- ** ***					autopsy perform	pr led? de	for to come ath?	pletion of cause of
ā	ificate or, pa	e Co	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes 2 ith (Check only one		⊒Yes 2	? L No
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 🎉 No	Hospital:	Inpatient 2	☐ ER/Outpatre	nt 3 DOA Oth	er	ome 5 Reside		r (Specify)	
0	ig Phys ter this neral di		27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time of	of 28c. Injur		28d. Describe ho	w injury occurre	d	
000	tanding F death. tor: After the funer	atic	1 Natural 5 Pendin 2 Accident investig	ation			M 1 🗆	Yes 2 □ No				
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	inad 288. Plat	ce of Injury - At ding, etc. (Spe	home, farm, st cify)	reet, factory, office		28f. Location (Str City or Town		r or Rural	Route Number,
	To the Hospital or Attanding I within 24 hours after death. To the Funaral Diractor: After completely filled in by the funer		29a. Certifier 1X Certifyin	a Physician To "	no hart of my !-	nowledge desi	th occurred at the ti	me date and place	and due to the co	use(s) and mon	ner se etc	ted
	Hos 24 ho Fun etely	edical		Examiner: On the			ivestigation, in my o					
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifie				29c. Licens	se number	29	d. Date signed	(Month, D	ey, Year)
	/ 1/		I stul your	D			Doos?	7600		3/15/04	Г	
. 1	4-15+1		30. Name and address of person	who completed ca	use of death (It	em 23a) (Type,	, Print)	1.				
5	r		GAIL BEOWN	an	251 E	· Anti	29c. Licens Doto 5:	Hagest	ammo	21740)	
	Sta Registi		31. Date filed (Month, Day, Year)	6 2004 32.	Registrar's Sig	nature	lak.)				
8	negisti	ar	110111 46	2004		10. 10	merel					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie () 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** WALLINGFORD 2235 M JENNIFER 04 NICOLE EB. 28 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner GROVE ADVENTIST ROCKVILLE

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | MONTGOMERY 8. Date of Birth (Month, Day, Year) FEB. 28; O Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 200 F **Funeral** MARYLAND NONE Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other then "natural", or thems 23a or 28a-f ehow any injury or other traumatic event, the Medical Examination. 10a. State 10c. City, Town or Location 10d. Inside Çity Limits JERMANTOWN 1 Nes 2 No MONTGOMERY Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20307 CEDARHURST WAY JSA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: à Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GARY WALLINGFORD DARLENE (HERESA NOMBOLD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALLINGFORD/FATHER 20307 WAY, GERMANTOWN MO JOHN GARY CEDARHURST 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MAR. 29,04 STERI 4 ☐ Donation 5 ☐ Other (Specify) CYCLE 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 9901 MEDICAL CENTER 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RON-VIABLE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending property for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ MICROGNATHIM 1 Yes 2 No 3 Probably 4 Unknown Completed CLEFT 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No director, page 2 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 24 hours after death.

Funerel Director: After this etely filled in by the funeral dir 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hour To the Fune completely fi (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ulion no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr. Rockville, MD 20PSO SGAH

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) APR 2 7 2004 32. Registrar's Signature

			1 - State Registrar	te of Marylan		artment of H			iene2004	13352
	Physici	an.	Decedent's Name (First, Middle, Last)					2. Date of Death Month	h Day Yeer	3. Time of Death
	/Medic		Henry Quentin	White				April_	13,2004	10:204
	Examin	er	4e. Fecility Name (If not institution, give street a				r Location of Dea	th	4c. County of Death	1
			6337 Teresa Lar 5. Social Security Number 6. Sex	7. Age (In yrs. i	last birthday)	La P		s. 8. Date of Birth	Char	Les place (State or Foreign
3	Funeral Director		544-24-9453 X ^M ²		Yrs.	Months Days	Hours Min	. (Month, Day,	15,1918	GA
			Usual Residence of Decedent					- CIND CL		
	anylar show	ų.	MD 10b. County Charles		∧Town or Lo a Pla					10d. Inside City Limits 1 ☐ Yes 2 X No
	8a-f	Director			a IIa			1 44		
	with the or 2		10e. Street and Number 6337 Teresa Lane			10f. Zip Code 206	1.6	10	Og. Citizen of What Cou	ntry?
	na 23	Funeral	11 Marital Ctatus	s Decedent Ever in U.	S. 13. 1			Specify Yes or No-	USA 14. Race - Americ	can Indian.
	r Iten	Fun	1 Never Married 2 XMarned 1 X	ned Forces?]Yes 2 □ No				Specify Yes or No- rto Rican, etc.)	Black, White,	etc.
<u></u>	ral', o	1 by	3 ☐ Widowed 4 ☐ Divorced Ye	es, Give ar or Dates:		1⊡Yes 2Ū V No	Specify:		Specify: W	hite
2	72 h	Completed	15. Decedent's Education (Specify only highest grade comp	oleted)	(Give	dent's Usual Occup kind of work done	during most of we		16b. Kind of Business/In	dustry
2	vithin ne. hen	ldm	Elementary/Secondary (0-12) Co	llege (1-4or 5+)		DO NOT use retired	,			a .
N	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)		Ете	ctricia		me (First, Middle, N	Federal	Govt.
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nid Mantla Hygiene. Indexed other than "natural" or Itema 23a or 28a-f show marked other than "natural" or Itema 23a or 28a-f show umatte event, it a Madical Evantinar must be routhed at	To Be	Henry Issaac Whit	:e				a Effie		
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Š	and 2 ealth a m 27 io		Julia White/Wife		6337	Teresa	Lane, I	La Plata	,MD 20646	
ore,	es 1 a of He of He I I tem		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Remova		lace of Dispo	sition (Name of natory or other place	ce)	Date 2	20c. Location - City or To	own, State
Ĕ	Pages ment of ant: If It ury or o		'4 □ Donation 5 □ Other (Specify)	Br:	insfi	eld-Ech	o1s 4/1	.5/04 C1	harlotte	Hall,MD
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic. <u>ance.</u>		21. Signature of Funeral Service Licensee	M90945	22	AREHART	-ÉCHOLS	FUNERA	L HOME, P.	Α.
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused the death	n. Do not ent	er the mode of dyir	A 36 / 1 ng, such as cardia	A PLATA ic or respiratory arre	,MD 20646	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	f .	VN	C C	AN	CFR		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):		71 1			
	Examiner		Sequentially list conditions. b. —							
-7	pa tis	Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury	Dué to (or as a consequ	rance of):					
	xecut and	хап	that initiated events	Due to (or as a consequ	uence of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit									
687	tificate ng phy as the	Physician/Medical	u			-				
Вох	eath certif attending for use a:	In/M	230. Was decedent pregnant	es, outcome of pregna		Ectopic pregnancy	,		23d. Date of delive	эгу
	res that the death igned by the atte be detached for	sicia	1 Yes 2 No	Pregnant at time of de		Other (specify)			Month	Day Year
<u>.</u> О	d by t	Phy	9 Unknown				1. 5	OC- Didash		and the state of
JS,	The law requires that the ite has been signed by th page 2 should be detache	þ	Part II. Other significant conditions contributing	ng to death but not rest	arting in the ui	nderlying cause giv	en in Parti.		acco use contribute to ti s 2 □ No 3 □ Prob	ne cause or death? hably 4 □Unknown
Ö	w require been sig should b	etec								
Records,	has ge 2 s	Completed						24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
		e Co	25. Was case referred to medical				00 81	1 ☐ Yes 2	□fo 1□Yes	2 No
Vita	nysician: The law nis certificate has l I director, page 2 s	o Be	examiner?	l: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth		ath (Check only one	nce 6 Other (Specif	
0	g Physerthis erthis	n: T	27. Manner of Death 28a	. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe how		//
<u>o</u>	utending F death. ctor: After y the funer	atlo	2 Accident investigation	(Month, Day roal)	injury .		Yes 2 □ No			
Division of	I or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e	. Place of Injury · At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rura State)	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1-Certifying Physician: (Check only one)	n the basis of examinat	wledge, death	n occurred at the tir vestigation, in my o	me, date and plac pinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as s te and place, and due to	tated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	d manner stated.		29c. Licens	e number	29	d. Date signed (Month,	Day, Year)
1	⊢ s ⊢ ŏ		* korela M	Matt.	-	12	F31)	4-14-0	VC
			30. Name and address of person who complete	ed cause of death (Item	23a) (Type,	Print) /) 1 1		0 - / 1	
1	BIZFIVA		10 130.	X 17	03	Lat	la Je	Md	7064	6
	Sta Registr		31. Date filed (Month, Day, Year) APR 16 2004	32. Projistrar's Signa	ture d	barde				

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 25, 12:00A M Ella G. Williams 2004 March /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gillcrest Center Townson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 12 1924 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 1 F 79 220-12-9821 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23e or 28e-f ahow the Medical Examiner must be notified at 1 Tyes 2 No Maryland N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21205 1102 Druid Hill Ave Apt. 214 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo 1 □ Never Married 2 □ Married \mathcal{M}/\mathcal{RM} // \mathcal{RM} 1 ☐ Yes 2 X No Specify: Specify: Black. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Plaza Hotel Cook 7th 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nannie Ennis Johnny Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 19a. Informant's Name/Relationship (Type, Print) Important: if item 27 is:
any injury or other traum Patricia Hamilton(Daughter) 1102 Druid Hill Ave Apt. 214 Baltimore, Md. Baltimore, 20b. Place of Disposition (Name of WO Codeles, Wanal Commercial Y 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-31-04 Baltimore, Md. * 4 Donation 5 Nother (SpecifyEntombment Wm. Reese & Sons Mortuary, F 821 West St. Annapolis, Md. 21. Signature of Funeral Service Licenses Larry D, Leese MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stroke **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): ding physician a Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Dunknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident by the f after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of d ath (Item 23a) (T e, Print) a riu is will trar's Signature 32. Reg Registrar

Naveh 25,2004

Please Type or Print in Black indelible ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygien [2] [1] [1] [1] [1] [1] [1] [1] [1] [1] [1	13354
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Phys		Robert Michael Woods								Month APRIL	2.20		Year	8:35	n N			
/Me Exan	dical iner	and the second s							4b. City, Town, or Location of Death FREDRICK					40	4c. County of Death FREDRICK			
		5 Social Security Number 6 Sex 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 B											olace (State	or Foreign				
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with th	I Director	10e. Street and N 2909 La	_{lumber} inder Ro	ad					10f.	Zip Code 21755	5				tizen of '	What Cou	ntry?	
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Baltimore, Maryland 21215-0036 bernit. Pages I and 2 should be filed within 72 hours all bepartment of Health and Mental hygiene. mportant; if item 27 is marked other than "natural", or my injury or other traumatic event, the Medical Examiny injury or other traumatic event, the Medical Examiny	þ		4 Divorced		If Yes, G Year or I	ive Dates:			1 🗌 Yes	2 (≛No	Specif	fy:			Specif	fy: W11.	rte	
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permit. Pag Department Important; any injury o	ouce.	21. Signature of Funeral Service Licensee																
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	23a. Pert1. Ente shock, or himmediate Caus disease or condi resulting in death Sequentially list if any, leading to cause. Enter the Cause (Disease that initiated ever resulting in death	eart failure. List e (Final tion 1) conditions, immediate deitying or injury nts	a b c	Cardi Due to	ac Ar o (or as a	9.	mia ence of):	er the m	lode or dyn	ng, such a	as cardiac o	or respiratory	arrest,			Approxim Interval Bo Onset and	etween
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME APRIL 3,2004

30. Name and address of person who completed cruse of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Registrar's Signature

31. Date filed (Month, Day, Year)
APR U 3 2004



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 13355 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** March 2004 12:00p M Rudolph Herbert Weber /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mallard Bay Care Center Cambridge Dorchester 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 M 2 □ F Yrs. 217-36-0288 67 April 19, 1936 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or itams 23s or 28s-f show tre Medical Examiner must be notified at 1 ☐ Yes 2 No Cambridge MD Dorchester Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 4159 Bestpitch Ferry Road 21613 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) farmer agriculture 12 marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I George Walter Weber Pauline Leonard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau 4159 Bestpitch Ferry Rd., Cambridge, MD 21613 Sally Weber wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/19/04 Bucktown Churchyard Cambridge, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic Physician concer /Medical **Examiner** 3 WEEKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical use as t the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed by I Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 s 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes 2 DNO 1 Yes To the Hospitel or Attending Physician: Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Puneral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated within 2 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier H0059973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Johnson, D.O. AMBRICE

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month

2004^{32. Redistrar's Signature}

9

State of Maryland / Department of Health and Mental Hygiene 100 L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Month Year 0liye Johnson Worrell 2004 1932 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Chestertown Kent 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct.13, 1926 Birthplace (State or Foreign Country)
 PA 5. Social Security Number **Funeral** 1 ☐ M 2 🛣 F Months 77 Yrs. Director 203-18-5070 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at Yes 2 No Director MD Chestertown Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 415 Morgnec Road, Apt. 302B 21620 **USA** or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2₩ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No þ Specify. 3 Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Data Processing Pages 1 and 2 should be filed an nent of Health and Mental Hygicant: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Sumame) Be ပ္ Charles Melvin Johnson Doris Rachel Boughner other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Worrell, Jr. /son 33 Maple Stream Rd, East Windsor,NJ 08520 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Slate permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation | 4-10-2004 Stevensville, MD 21666 21. Signature of Funeral Service License ODC8. Fellows, Helfenbein & Newnam Funeral Home, P.A. Kirk 370 Cypress Street, P.O. Box 270, Millington, MD o not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) >5yrs Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) use as the burial-P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregp 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referre medical examiner?
1 Yes 2 No Be 26. Place of Death Check on one Hospital: 1 Inpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 FR/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation M 2 Accident the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 296. Signature and title of 29c. License number D 3605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESTENOON MI ATRICIO 120 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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	Physici /Medic		1. Decedent's Name (First, Middle, Las	BSINIA	Wil	Son		2. Date of Dea Month	3 Say	Year 4	3. Time of Death p	
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	th the Ma or 28a-f s e retifies	lirector	MD KENT 10e. Street and Number		WORTON	10f. Zip Code			10g. Citizen of V	Vhal Coun	1 Yes No	
5-0036	72 hours after death with the Maryland *natural; or itema 23a or 28a-1 show olical Executer court be notified at	Completed by Funeral Director	25647 WEST HII 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		21678 Was Decedent of F f Yes, specify Cub 1 Yes X No	Hispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	Blac	e - America k, White, e	CK	
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Maryland	2 should be and Mental is marked c	To Be (17. Father's Name (First, Middle, Last) Asbury Gilbert 19a. Informant's Name/Relationship (7				Birdie					
			Dorothy Wilson 20a. Method of Disposition	- Daught	er 2545	ng Address (Street 2 Still sition (Name of matory or other pla	Pond N			n, MI	21678	
Dorothy Wilson - Daughter 25452 Still Pond Neck RD Worton, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4/8/2004 Worton 21. Signature of Funeral Service Licensee Walley F. Service 821 W. St. Annapolis,										ral 21401		
8760,	Physician and /Medical Examiner tunsit the prutal-transit	dical Examiner	23a. P. 1. Effer the disease, or composed to the cause (Final disease or condition resulting in death) Sequentially list conditions, 134 1350 15 15 15 15 15 15 15 15 15 15 15 15 15	a. Due to (or as a b. Due to (or as a c.	consequence of):		Λ		e FL		Approximate Interval Between Onset and Death Q Clay S	
P.O. Box 687	that the death certificated by the attending phy detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy	y		23d. Dat Moi	e of deliver	ry Day Year	
	The law requires ate has been sign page 2 should be		Part II. Other significant conditions of Chromic Rend	entributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to			e cause of death?	
of Vital Records,		Completed by	Insulin Den	Are Coron	paresedo	Mellitz	5	24a. Was a autop perfor	sy p	rior to com leath?	sy findings available apletion of cause of	
f Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Impatien	t 2 ER/Outpatien		ner: 4 Nursing H	ath <i>(Check only of</i> Iome 5 ☐ Resid		er (Specify,)	
Division o	Jing After	1 Natural 5 Pending (Month, Day Year) Injury Work? 1 Yes 2 No								v injury occurred set and Number or Rural Route Number, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	rsician: To the best of iner: On the basis of e and manner state	examination and/or inv	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	o, and due to the corred at the time, co	ause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	Ross in	P.	29c. Licens	o 36	2	29d. Date signed	(Month, E	Pay, Year)	
			30. Name and address of person who of Sus in K. Loss,	ompleted cause of dea	ath (Item 23a) (Type, Washingt	Print) Are.	Chest	Arm	md a	2/60	20	
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 6	32. Regitrar	's Signature	1. 0						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 0 4 UNK 04-074 For State Ragistrar 13358 04 - 1761Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** CHARLOTTE WRIGHT ANN March 10, 2004 9:20 /Medical Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 106 Beachside Drive Stevensville Queen Anne's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) 4-1-55 Birthplece (State or Foreign Country) **Funeral** 1 M 2 DF 214-66-7528 48 MARYLAND Director Usuel Residence of Decedent with the Maryland 10b. County 10c, City, Town or Location show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryiai ment of Health and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show ury or other fraumatic event, the Modical Examiner must be notified at Directo 1 ☐Yes 2 ☐ No DELAWARE SUSSEX MILTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 palmer street 19968 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING SELF.

18. Mother's Name (First, Middle, Maiden Sumarne) 17. Father's Name (First, Middle, Last) Be THOMAS F. WRIGHT ပ္ DEC LILLIAN OCTAVIA HACKETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THELMA L. HARVEY 404 YEW STREET MILTON DE.19968 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. ⁴ 4 □ Donation CAPITOL CREMATORY 3-16-04 DOVER DELAWARE 21. Signature of Funeral Service Moensee 22. Name and Address of Facility 222 north queen st.dover delaware author 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Drowning complicated by my pothermia and chest injuries **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2 □ No autopsy performed? certificate 1 Yes Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home MYes 2 No ۴ 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 5 Residence 6 ☑Other (Specify) At SCENE this 28d. Describe how injury occurred from bridge 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After Injury 1 Natural 5 Pending investigation after death. -15-04 16:12 PM 1 ☐ Yes 2 XNo 2 Accident

P.O. Box 68760 Division of Vital Records. or Attending Physician: within 24 hours after To the Funeral Dire

Baltimore, Maryland 21215-0036

State Registrar

Medical

6 ☐ Could not be

determined

3 Suicide

29b. Signature and

29a. Certifier

4 Homicide

31. Date filed (Month, Day, Year) 1700 0 111 Penn Street, Baltimore, Maryland 21201 32. Register's Signature 6

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

281. Location (Street and Number or Rural Route Number. City or Town, State) Northern Prind Col.

U.S. 50 W/B near mile walter 36. MD.

29d. Date signed (Month, Day, Year)

March 11, 2004

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northern lavidge

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 13359 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2004 Η. WELLS March 11, 8:05 am /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Wing, Heron Point Chestertown Kent 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 90 Director 218-34-3122 Feb 1,1914 Penna Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 77 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Medical Examinan must be modified at 1 ☐ Yes 2 ☐ No Director MD Kent Chestertown 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Apt. 211 Heron U.S.A. Point 21620 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Itsm 271s marked other than "naturel", or Itel may injury or other traumatic event, the Medical Examplest Anda. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Hollinger Arabel Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Pox 264 Chestertown, J. Willis Wells (husband) MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Old St. Paul's 3/15/04 Chestertown, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Galena Funeral Home of Stephen Schaech 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition END STAGE DEMENTIA **Physician** 3 year resulting in death) /Medical Due to (or as a consequence of): Examiner YRMS PARKINSONS DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): the attending physicien Box 68760 Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy ō Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, pe 1 ☐ Yes 21 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? certificete 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 9 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D004158 MAR 12, 2004 who completed cause of death (Item 23a) (Type, Print) NOBL EMDIZZ CHESTERTOWN MD SPEAR 31. Date filed (Month, Day, Year) 32. Regist s's Signature State MAR 1 8 2004 > Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

				Otate of Mi	ai yiai k	Cer	tificate of	Death	ı Mentanı	reg. No.	04	13360	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Y									3. Time of Death	
4	Physicia /Medic												
أبجر	Examin		4a Facility Name (If not institution, g	or Location of Dea			Death						
			Casey House					Le,	Montgomery				
	Funeral		1	Sex 7.Ag 1□M 2MXF		st birthday)	If Under 1 Year Months Days		in. (Month, D	ay, Year)	9. Birthpl Coun	lace (State or Foreign try)	
	Director		058-44-6564 Usual Residence of Decedent		52	Yrs.			July 1	2, 1951	New Y	York	
	land		10a. State 10b. County		10c. City,	Town or Loc	ation				10	0d. Inside City Limits	
Many	Mary First	to	Maryland Montgon	027	Roth	esda						1 ☐ Yes 2 🔯 No	
	h the	<u>e</u>	10e. Street and Number	iel y	Deci	lesua	10f. Zip Code			10g. Citizen of W	/hat Count	try?	
	th wit	aiD	10655 Montrose Av	enue Apt.	3		20814			USA			
	dea	Iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S	i. 13. V	/as Decedent of I	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)	0- 14. Race	- America k, White, e		
2	be filed within 72 hours after death with the Maryland ital Hygiene. of other then "naturel", or items 23a or 28s-1 show event, the Medical Examiner must be notified at	Be Completed by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2X 1 If Yes, Give			☐ Yes 2☐XNo		,	Specify:		no.	
0200-91212	ure!,	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	r Dates:						te		
5	n 72 nat	lete	15. Decedent's E (Specify only highest gi	16a. Decedent's Usual O (Give kind of work d life. DO NOT use n			pation during most of w	vorking	16b. Kind of Business/Industry				
7	with iene.	E	Elementary/Secondary (0-12)	College (1-4or 5 4						Professional Recrui			
	Hiled Other	Ö	4 Technicial Recruiter Profess 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname									<u> </u>	
<u>a</u>	should be nd Mental merked o		Daniel George Wei	ner				Dorothe	a Levy				
Maryland	€ 5 E E		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S.									Code)	
	and 2 aaith a n 27 is		Allivon Van Zandt	/ daughter					#2 Port1	and, OR	97201	L	
o e	of H	- 1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Removal from State	20b. Pla	ice of Dispos metery, crem	ition (Name of atory or other pla	ce)	March	20c. Location - 0	Dity or Tow	vn, State	
Ē	Pages ment of ant: If Its ury or o		4 □ Donation 5 □ Other (Special	fy)	W.	Arunde	el Crema	tory	22,2004	Odenton	, Mar	yland	
saitimore,	permit. Pag Department Important: I any Injury o pncs.		21. Signature of Funeral Service Lice	11		22. Gc	Name and Addre	ess of Facility	ion Serv	ice P.O	- Box	784	
_	90 E 9 9		Beverly L. H	exhitte	MO1							MD 21029	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin								Approximate Interval Between	
	Physician										(Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition a Ovarian Cancer resulting in death)										
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5	the at	350	Part II. Other significant conditions	ontributing to death bu	t not result	ing in the un	derlying cause giv	en in Part I.	23b. Did	tobacco use cont	ribute to 1	the cause of death?	
-	d by	5		1 🗆	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown								
'n	signe d be	20		-									
2	nedu Deen Shouli	Сотріете								24a. Was an autopsy performed? 24b. Were autopsy findir available prior to completion of cause			
	has b	틸							25.000			eath?	
5	ficata ficata		OF Management and the manking to						10		10	Yes 2□ No	
5	certification	D	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ TNo	Hospital:		2/0	Oth		eath (Check only o				
5	Phy or this eral d	2	27. Manner of Death	1 ☐ Inpatier	y 2	R/Outpatient 8b. Time of	200. 111141	y cat	28d. Describe	dence 6 🔀 Other	(Specify)] d	hospice	
5	ath. :: Afte	<u>at 10</u>	1 Natural 5 Pending 2 Accident investigatio	(Month, Day	Year)	Injury	Wor M 1□	k? Yes 2 ⊡No					
2	After dector by the		3 ☐ Suicide 6 ☐ Could not be determined		ry - At hom	e, farm, stree	et, factory, office		28f. Location (Bf. Location (Street and Number or Rural Route Number, City or Town, State)			
2	s after	Certification:	4 Li Homolgo	building, etc.	. (Эрвспу)				City of Tol	WII, SIAIO)			
			(Check only 2 Medical Exar	ysician: To the best of niner: On the basis of	f my knowle	edge, death o	occurred at the tin	ne, date and place	ce, and due to the	cause(s) and mani	ner as stat	led.	
	the the the print 24 the F	_	Girey	and manner stat	ed.								
	5 × 5 0	2	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed	(Month, Da	ay, Year)	
•	60	Chihe apaphie D42452 March 20, 2										4	
	(1/10)	~ I	30. Name and address of person who		-		-	0.1	MD 0000	,			
			Chitia Rajagopal I 31. Date filed <i>(Month, Day, Year)</i>	1.D. 18111 32. Registra			TTIP Dr.	Oiney,	MD 20832	<u> </u>			
	State Registra	-	MAR 2.2		1.7		A. w.						
		.5	MIAK & &			AS A	10847						

State of Maryland / Department of Health and Mental Hygiene 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** March 16, 12:50 PM Harry Zupp /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Chestertown Nursing & Rehab. Ctr. Kent Chestertown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 11, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□**™** 2□ F 098-32-1792 Germany Director 78 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturs!, or items 23s or 28a-f show any njury or other traumatic event, its Martical Examiner must be nytitled at once. 1 ☑ Yes 2 ☐ No Director MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8720 Mount Hope Road Completed by Funeral Germany 12. Was Decedent Ever in U.S. Armed Forces? 1 XX ves 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Masonary Contractor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Heinrich Zupp Emma Wuttke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonie Zupp 8720 Mount Hope Road, Chestertown, Maryland 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 3/18/2004 Stevensville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Fellows, Helfenbein & Newnam Funeral Home, 130 Speer Road Chestertown, Maryland 21620 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, only arritable. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Deludation

Due to (or as a consequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy detached for Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 99 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 25 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Medical TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Frederick Delboy, M.D. 6602 Church Hill Road, Chestertown, Maryland 21620 32. Regis ar's Signature 31. Date filed (Month, Day, Year) MAR 1 8 2004 Registrar

Physic /Med Exami	ical	1. Decedent's Name (First, Middle, Las Paul H. Adler 4a. Facility Name (If not institution, give	street and number)	Oel		of Death		eath 27, Day 2004 Year 4c. County of Dea	3. Time of Death 6:00 A M
Funeral		Chapel Hill Nursi 5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday)	Randal If Under 1 Y Months Da	1stown	Hrs. 8. Date of Bi	Baltimor 9. Bir	thplace (State or Foreign
Director		Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor		Yrs. 7, Town or Lo	cation	ays Hours	Hrs. 8. Date of Bi (Month, D Nov 27	, 1913 Rho	ountry) de Island 10d. Inside City Limits 1 □ Yes 2 ☒ No
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Medical Examinational Remodified at	Completed by Funeral Director	10e. Street and Number 391 Butler Rd. 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 15. Decedent's Ed (Specify only highest grade procedure) Elementary/Secondary (0-12) 12th	12. Was Decedent Ever in U.S Armed Forces? 1 ⊠Yes 2 □ No 19 If Yes, Give Year or Dates: 1946	13. v 13. v 14. 2 - 16a. Deced	10f. Zip Coo 2113 Vas Decedent 'Yes, specify (of Hispanic Origin Cuban, Mexican, F No Specify: ecupation one during most of tired)		Specify: WI 16b. Kind of Business Sears Roeb	tes erican Indian, te, etc. hite
d 2 should be filed within in the and Mental Hygiene. 27 Is marked other than "	To Be	17. Father's Name (First, Middle, Last) Walter H. Adler 19a. Informant's Name/Relationship (7	vne Print)	19h Mailin	a Address /St	Viola	Name (First, Middle Parent	e, Maiden Surname) per, City or Town, State, a	7in Conto
Page nent c int: If		Marcia Young (Nie 20a. Method of Disposition 1⊠Burial 2 □ Cremation 3 □ 1 4□Donation 5□Other (Specify,	CE) 20b. Pla 20b. Pla ce	4500 ace of Dispos		r Tail D		ead, MD 210 20c. Location City or Woodstock,	74 Town, State
permit. Departn Importe any inju		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp	Elm	Bu 12	rrier-	dress of Facility Queen Fu Old Libe	neral Dir	ectors, P.A infield, MD	21784 Approximate
Physician / Medical Examiner and prize pri	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Atherosch Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	ence of):	c Co	101-ry	V-1-/-	Dige-se	Interval Between Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of the pregnant at time of decent of the pregnant at time of decent of the pregnant at time of th	death 3□	Ectopic pregna Other (s <i>pecify</i>			23d. Date of del Month	ivery Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but not resul			given in Part I,	_ 10	robacco use contribute to Yes 2 No 3 Pr	obably 4 Inknown
taw 2 as	Completed	25. Was case referred to medical	-,,,			Of Pines of		psy prior to death? 2 No 1 □ Yes	topsy findings available completion of cause of
an: The ta tificate ha tor, page 2	e e	avaminar?	lospital:	R/Outpatient	3L DOA	Other: 4 Nursir	ng Home 5 🗆 Resi	dence 6 □Other (Spec how injury occurred	cify)
nding Physician: The lath: ath. rr: After this certificate ha ne funeral director, page	To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	28b. Time of Injury	28c. li M 1	Work? I □ Yes 2 □ No			
tending Physician: eath. :or: After this certifics the funeral director. p	o Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 E	28b. Time of Injury	M 1	I □ Yes 2 □ No	28f. Location (: City or Tou	Street and Number or Ru wn, State)	ıral Route Number,
tending Physician: eath. :or: After this certifics the funeral director. p	edical Certification; To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27 No 2 No 2 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hon	28b. Time of Injury ne, farm, stre	M 1 et, factory, offi occurred at the estigation, in m	Yes 2 No	ace, and due to the	wn, State) cause(s) and manner as date and place, and due	stated. to the cause(s)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 No.	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hon building, etc. (Specify) sicien: To the best of my know ner: On the basis of examination and manner stated.	28b. Time of Injury ne, farm, stre	M 1 et, factory, offi occurred at the estigation, in m 29c. Lice	Yes 2 No	ace, and due to the	wn, State)	stated. to the cause(s)

		1 - For Amend Item #20 Registrar	State of Manyland	//Oepa Ce	utment of I	lealth and Death	Mental Hy	/giene Reg. No.	2004	1336
Physic	cian	Decedent's Name (First, Middle, Las.)				2. Date of D Month	eath Day	Year	3. Time of Death
/Med		Vincent Jero	me Arends				April	25	2004	3:40 P
Exam	iner	4a. Facility Name (If not institution, give				or Location of De	ath		County of Death	
		12202 Mount Pleas			Laui		50 Tab (D)		ince Ge	
Funera Directo		512-42-6/22	XM 2 F 7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours M		ay, Year)		plece (State or Forei intry) NSAS
and		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	cation					10d. Inside City Limit
Aaryli aho	ō									1 □ Yes 2/0XN
the h	Director	MD Prince	George's I	Laure	10f. Zip Code			10a Citiz	en of What Cou	inta/?
with sa or	0					===		rog. Oniz		
ne 2:	era	12202 Mount Plea	12. Was Decedent Ever in U.S.	13.1		1708 Hispanic Origin?	(Specify Yes or N	0- 1	USA 4. Race - Amer	ican Indian.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 23a-f ahow any injury or other traumatic event, Ita Meulcal Examinar must be notified at once.	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 yes 2 No 1963 If Yes, Give Year or Dates: 1969	3-	Yes, specify Cub	an, Mexican, Pu	(Specity Yes or N erto Rican, etc.)		Black, White	
n 72 hou "natura edical E	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Deced	lent's Usual Occu kind of work done OO NOT use retire	pation during most of w	rorking	16b. Kin	d of Business/Ir	
within lene. then "	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)		ctronic			Cor	mputer :	Firm
filed Hygir other	ပိ	12th 17. Father's Name (First, Middle, Last)	4			,	ame (First, Middle		-	
d be antal	00		- F							
2 should and Mer is marke	은	Nicholas Lewis . 19a. Informant's Name/Relationship (T.		19b Mailir	n Address (Street		Wendtlar Rural Route Numb		Town State 7	n Codel
od 2 s lith ar 27 is 1 trau	1	V. Carol Arends/W					Drive, I			20708
Health Health tem 27		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of	1	Dirve, 1	,	ation - City or T	
Pages nent of ant: If It		14 Burial 2 Cremation 3 1	Removal from State Ft. Line	ncoln (enetery of other pla	ce)		Brents	wood, MD	
artme ortan		* 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	Tread		Ge Mom.		30/2004 Donaldsor	Fike		4D D A
permit. Departr Importa any inju			M00160				ie, Laure			
Physician /Medical Examiner sthe private parameters of the private par	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Amyotroph Due to (or as a consequent Due to (or as a consequent Due to (or as a consequent Due to (or as a consequent d.	nce of):	teral Sc	lerosis				Onset and Death
The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetel de 4 Pregnant at time of deat	eath 3	Ectopic pregnanc Other (specify)	y		23	d. Date of deliv	ery Day Year
w requires that been signed b should be det	by	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the ur	derlying cause giv	ren in Part I.				he cause of death?
ne law req n has beer ge 2 shou	Completed			-			24a. Was		24b. Were auto prior to co death?	opsy findings availab impletion of cause of
ician: Th certificate ector, pag		25 111					1 ☐ Yes		1 🗆 Yes	21x No
sicial certii recto	Be	25. Was case referred to medical examiner?	Hospital:		27 204 Ott	ar	eath Check only			
Phys r this ral di	- T	1 Yes 2 No	I Inpatient 2 LEF	VOutpatien 3b. Time of	3 DOA	4 Nursing	Home 5 Resi			(y)
Attending Physician: r death. sctor: After this certifice by the funeral director.	cation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k?" Yes 2□No				
s after d al Direct ad in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	et, factory, office		28f. Location (City or To	Street and wn, State)	Number or Ruri	al Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1X Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tri estigation, in my o	me, date and pla- pinion, death oc	ce, and due to the curred at the time,	cause(s) a date and p	nd manner as s lace, and due to	itated. o the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
, (Maramo	we atom		D23	743		April	. 26, 20	004
WAY,		30. Name and address of person who co	1	3a) (Type. I	Print)					
MIN.		Martin Weltz,				reenbelt	MD 207	770		
	1		, JZJ OF CCIIIIA, C	COL	D 0, 0	TOOLINOT				

DHMH 17 Rev 1/2001

			1 - For State Registra AMEND TIEM #8,	State of Maryla 16b,17&18 PER FH	nd / Departm	nent of H	ealth and Death	Mental Hygi	ene 20	04	13361
	Physic		1. Decedent's Name (First, Middle, Las					2. Date of Death Month		Y0004	3. Time of Death
02	/Medi Examir Funeral		4a. Fecility Name (If not institution, give 1121 ST. AGNES L 5. Social Security Number 6. Sec.	street and number) ANE APT. 4 7. Age (In yrs	4b.	BALTI Inder 1 Year	Location of Dea MDRC If Under 24 Hr	s. 8. Date of Birth		UT I M	ce (State or Foreign
	Director	ı.	2 8 2 8 3 9 5 1 1 Usual Residence of Decedent 10a. State 10b. County MD EALTIM	10c. C	ity, Town or Location		Hours Mir	h. (Month, Dey, O3 12)	Yeer) 1933 1932	Countr	d. Inside City Limits
	with the Ma 3e or 28s-f	i Director	10e. Street and Number		3ALTIMO	f. Zip Code 212	.07	10	g. Citizen of W	/hat Countr	1 ☐ Yes 2 ☑ No y?
2-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28s-1 show other traumatic event, the Mcdical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 SYes 2 □ No If Yes, Give Year or Dates:	i	Decedent of Hi , specify Cuba es 2 XNo	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		- American k, White, et	
21215-0	filed within 72 ho Hygiene. ther then "natur int, the Mcdical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		of work done d OT use retired,	ution luring most of wi PLOYED	orking	6b. Kind of Bu		IAL SERVICE
Maryland 2	should be filed nd Mental Hygi marked other amatic event, II	To Be C	17. Father's Name (First, Middle, Last) SIMPSON ANDERSON 19a. Informant's Name/Relationship (7		19h Mailine Ad	Trace /Stract	PEFIE	SULLIVAN Bural Route Number.	aiden Sumami) UNK	
Baltimore, Ma	00 = =		PAUL ANTHONY 20a. Method of Disposition 1 Burial 2 Cremation 3 '4 Donation 5 Other (Specify	ANDERSON 20b.		(Name of or other place	NTONIO	AVENUE Dete 2	Oc. Location	City or Town	CA 9450
Balti	permil. Page Department of Important: If eny injury or		21. Signature of Fure al Service Licely		22, Nam VAU SIS	e and Address CHN (PAUTI	s of Facility CAZENE MCLEN	FUNERAL HTIONAL PIK	ervic Z Bayr	دو	
760,	Physician /Medical Examiner	cal Examiner	23a. Pert1. Enter the disease, or compositive, or beart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	tive Hear quence of): Dya pathy quence of): y Arter	8 mm 1	lure	ac or respiratory arres	st,	11	oproximate interval Between phase and Death S years 8 years 10 years
. Box 68	death certific e attending pl d for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feto 4 □ Pregnant at time of o 9 □ Unknown	el death 3 □Ectop	pic pregnancy r (specify)			23d. Date Mon	of delivery	ay Year
rds, P.	The law requires that the ste has been signed by the bage 2 should be detached.	þ	Part II. Other significant conditions co	entributing to death but not res	sulting in the underly	ing cause give	n in Part I.	23e. Did toba			cause of death?
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5	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Othe		ath <i>(Check only one)</i> Home 5 ⊠ Residen	1000	(Spacific)	
Division o	ding After fune	Certification; T	27. Manner of Death 1 Naturai 2 Accident 3 Suicide 4 Homicide 2 Homicide 4 determined	28a. Date of Injury (Month, Day Yeer) 28e. Place of Injury - At h building, etc. (Speci	28b. Time of Injury M			28d. Describe how 28f. Location (Stre City or Town,	injury occurre	d	Route Number,
۵	Hospital A hours Funeral ely filled	edical Cer	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, death occur	rred at the time	e, date and plac inion, death occ	e and due to the cau	sa(s) and man	ner as state	ed. ne cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier Suarklad	lus		29c. License		290	Date signed	(Month, Da	y, Year)
	Sta Registr		30. Name and address of person who come to the state of t	ompleted cause of death (Item Baltimore 32. Registrar's Signi	m 23a) (Type, Print) VANC [9 ature	ON.G	reeve S.	t. Baltir	none, M	1/21	20/

				1 - For State Registrar		State	of Ma	aryland	-			lealth an Death	d Mental		20	0.1	100-
		Physic	ian	1. Decedent's Nam	•		-		-	inoai	011	<i>504111</i>	Mont	of Death	Day 11	Year	3. Time of Death
		/Medi Examir			ANGELA If not institution	GERINA n, give street and nu		AVER	Y	4b. City.	Town, or	Location of D	Peath P	r!	4c. County	26 0 4	23:05 M
	1	LAGIIII	ici	7.1		KE MEDICA		ENTER		•	AIR					FORD	CO
		Funeral Director		5. Social Security N 288-62-64	189	6. Sex 1 ☐ M 2 X F	7. Ag	e (In yrs. las 32	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min. (Mon	h, Day, Y			ace (State or Foreign
		and		Usual Residence o	f Decedent 10b. County			10c. City	Town or Lo	ration						14	Ad Incide City I fraise
		Marylan f show	ō	MARYLAND	·	FORD CO			GUNPOV							10	0d. Inside City Limits 1 ☐ Yes 21 No
		r 28a	Director	10e. Street and Nu		FORD CO		l	JUNPON	10f. Zip	Code			100	g. Citizen of W	hat Count	
		th with		1119	B BUSH	RIVER CI	RCL	E			210	10			U.S.A		
10		ltams	Funeral	11. Marital Status		12. Was Dec Armed F	orces?		13. V	Vas Deced Yes, spec	lent of Hi	spanic Origin n, Mexican, P	? (Specify Yes uerto Rican, etc	or No-		- America	
9	36	rs afte	by Fu	122Never Marr 3 ☐ Widowed		If Yes, Gi	ive	No		□Yes	_	Specity:		,	Specify:		
230	5-0036	2 hour	ed		15. Decedent	Year or E			16a. Deced	ent's Usua	LOccupa	ation		16	Sb. Kind of Bu	DLAC	
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	2	filed wit Hygiene ther tha	Con	0yrs				'	DISA	BLED					N/A		
	Maryland	tal do	Be	17. Father's Name									Name (First, M		iden Sumam	a)	
	Ĕ	d 2 should th and Men 7 is marka traumatic	은	RUFUS A					10h Mailin	- Add	/Can 1 -		IE AVER				
	<u>≅</u>	ad 2 state at the art trau		Minnie									<i>r Rural Route N</i> Circle,				
118/04	Je,	T T T		20a. Method of Dis	position			20b. Plac	e of Dispos	ition (Nam	e of		Date		c. Location - (
100	Ē	Pages nent of thant. If its ury or of		1 ☐ Burial 2/ `4 ☐ Donation	MCremation 5 ☐ Other (Sp	3 □Removal from	State	1	rro ci			* I .	-21-04	В	ALTIMO:	RE, M	ARYLAND
1/1	Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of St	plant stems	HUUUU	,		W	I C BI	ROWN	s of Facility COMMU	NITY FU IA BLVD	NERA	L HOME	-HARF	ORD, P.A.
				23a. Pagt. Enter I shock, or hea	he disease, or	complications that conly one cause on e	aused	the death.	Do not ente	r the mode	of dying	, such as car	diac or respirate	ory arrest	,		Approximate Interval Between
		Physician		Immediate Cause disease or condition	(Final	Bil	at	rel	Sx	tons	we	he	umon	een			Onset and Death
		/Medical Examiner		resulting in death)		Due to	(or as	a conseque	nce of):								- Carl
1	M		er	Sequentially list co if any, leading to in	nditions, mediate	b	(or as a	a consequer	nce of):								
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	ő	sician and burial-transit		resulting in death) i	Last		(or as a	eupeanos E	nce of):								
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FR	Box	Physician: The law requires that the death certifi this certificate has been signed by the attending ral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent in the past 12	months?	1 ☐ Live t	oirth	or pregnanc 2 Fetal de time of deat	eath 3⊟	Ectopic pre Other (spe					23d. Date Mont		/ Day Year
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4	S, D	es thai igned t	by P	Part II. Other signif	icant conditio	ns contributing to d	eath bu	ıt not resulti	ng in the un	derlying ca	use give	n in Part I.	23e.	Did tobac	co use contrib	ute to the	cause of death?
	ord	v require been sig should t											- H	I □ Yes	2 No 3	☐ Probat	oly 4 □Unknown
ANGELA	Vital Records,	e law r has be ge 2 sh	Completed										8	Mas an	pr	or to comp	sy findings available bletion of cause of
T	al F	ician: The certificate harector, page											1 🗆 Y	erformed es 2	d? de	ath? Yes 2	
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	ion	Attanding I r death. actor: After by the funer	atlo	1XNatural 2 ☐ Accident	5 Pending investig		th, Day	Year)	Injury	М		? es 2 □ No					
50	Division	r Atta	Certification:	3 🗍 Suicide 4 🗍 Homicide	6 Could n determi	ned 286. Place	of Inju	ry · At home . (Specify)	, farm, stre	et, factory,	office	3303	28f. Locati City of	on (Stree Town, S	t and Number	or Rural H	Route Number,
18	Q	urs af urs af eral D			S-6										,		
#401836		To tha Hospital or Attandi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	2 Medical E	Physician: To the examiner: On the base and man	asis of	examination	idge, death and/or inve	occurred a estigation, i	t the time in my opi	e, date and pla nion, death o	ace, and due to ocurred at the ti	the caus me, date	e(s) and man and place, an	ner as stat d due to th	ed. ne cause(s)
F		To the To the comp	×	29b. Signature and	title of certifier	4/2				29c.	License	number		29d.	Date signed	Month, Da	y, Year)
)			•	-		MI			2	00	5660	7	A	pril 19	, M	2004
		3			1 AN	GELO,	#	106	3a) (Type, P	rint)	2	ATU	1000 K	0, 1	BELA	IR	2004 MD 21014
		Sta Registr		31. Date filed (Men	R 2 8"	2004	egistra	r's Signature	B	ppa	1.63						

		•	For State Registrar	State of Marylan	•	artment of rtificate of		R	eg. No. 20	04 13356
	Physici /Medio	an al	1. Decedent's Name (First, Middle, Last) Theodore John Aug	zustyniak, Ir	•			2. Date of Dea Month April	24, 20	
	Examir	ei	4a. Fecility Name (If not institution, give at 3423 Kenyon Avent 5. Social Security Number 6. Second	ie	last birthday)	If Under 1 Year		s. 8. Date of Birth	9	N/A Birthplace (State or Foreign
	Funeral Director	}	219-40-6771 15 Usuel Residence of Decedent	IM 2□ F 60	Yrs.	Months Days	Hours Min		, Year)	Maryland
	he Marytar 8e-f show ctiffed at	Director	10a. State 10b. County Maryland N/A	10c. Cit	y, Town or Lo	Balti	more	т.	log. Citizen of Wh	10d. Inside City Limits 1 Yes 2 □ No
(0	4 within 72 hours after death with the Maryland liene. rthen "natural", or Items 23a or 28e-f show the Medical Examinat must be multified at	Funeral Dir	10e. Street and Number 3423 Kenyon Avenue 11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No	i	Was Decedent of I Yes, specify Cul		Specify Yes or No- into Rican, etc.)	U. 14. Race - Black,	S. A. American Indian, White, etc.
21215-0036	in 72 hours a "natural", o ledical Exam	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	e completed)	16a Deced	1 ☐ Yes 2 💆 No dent's Usual Occu kind of work done DO NOT use retin		orking	Specify: 16b. Kind of Busin Mrs. I	,
	e file othe	Be Comp	Elementary/Secondary (0-12) 12th Grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		oute Sal	esman	ame (First, Middle,	Potato	
Maryland	d 2 should be th and Menta 7 is marked traumatic ev	2	Theodore J. Augus:	pe, Print)		V-1749	et and Number or I	NOT FOSTE Rural Route Number	r, City or Town, St	
Baltimore, I	of Heal of Heal if item 2	I II	Jane Augustyniak 20a. Method of Disposition 1 □ Burial 2 ØCremation 3 □ F 1 □ Donation 5 □ Other (Specify)	20b. Flemoval from State	Place of Dispo cemetery, crer	Kenyon sition (Name of matory or other pla Cremator	ace)		20c. Location - Ci	
Baltir	permit. Pag Department Importent: any Injury once.		21. Signature of Funeral Service Licens	The state of the s	22	2. Name and Addi	ess of Facility	Schimunek	Funeral	11.00
	Fnysician /Medical Examiner	0	23a. Part. Enter the disease, or composition speck, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	broni		+ + 1		duese	Approximate Interval Between Onset and Death
3760,	ate be executed hysician and he burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the consequence of t						
P.O. Box 68	The law requires that the death certificate be ate beas been signed by the attending physicia page 2 should be detached for use as the but	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	ıldeath 3□	Ectopic pregnand Other (specify)	cy		23d. Date of Month	
	w requires that been signed b should be deta		Part II. Other significant conditions con	ntributing to death but not res	culting in the u	nderlying cause g	iven in Part I.	23e. Did to		ute to the cause of death?
al Records,	hysiclen: The law r his certificate has be I director, page 2 sh	Completed by	0		J 			24a. Was a autops perform	sy prio moed? dea	re autopsy findings available or to completion of cause of tth? Yes 2 \sum No
of Vital	D - 40	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien	I 3L DOA	ther: 4 \(\text{Nursing}	eath (Check only or Home 5 Residence 128d. Describe h		
Division	c = =	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	Injury ome, farm, str (y)	M 1[]Yes 2□No	28f. Location (S City or Town		or Rural Route Number,
Ω	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Cer		sicien: To the best of my kno ner: On the basis of examina and manner stated.						
	To the within To the comple	Me	29b. Signature and title of certifier				ose number	2	9d. Date signed (Month, Day, Year)
	5		30. Name and address of person who co	J GBU		Print) 6701 ,	V. Charl	sst, B	cltimure	, led 21204
	Sta Regist		31. Date filed (Month, Day, Year) APR 2. 8 2004	32. Registrar's Signa	ALUFO DE LA CONTRACTOR	Sparks	/			

			For State Registrar	State of Maryla		artment of rtificate of	Health a		•	2001	13367
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, La Eleanor 4a. Facility Name (If not institution, gin Good Gamar	Am+ re street and number) 1+an Hosp		4b. City, Town,	or Location of	of Death	April 2	Day Year 2004 C. County of Dee	3. Time of Death 9.47 PM
-4.	Funeral Director			Sex 7. Age (In yrs 1 □ M 2 131.F 91	s. last birthday, Yrs.	Months Days		24 Hrs. 8. D	ate of Birth Month 50ay 501	2 Mary	tholace (State or Foreign Putty) Land
	ne Maryland 8a-f ehow	ector	Maryland 10b. County	10c. C	Baltir	more City	7				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Dir	10e. Street and Number 5000 Eugene Avenu	10		10f. Zip Code	21206		10g. C	Citizen of What Co	•
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or Items 23e or 28e-f ehow any injury or other traumatic event, the Madical Exacting must be rotified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu	Hispanic Orig ban, Mexican	gin? (Specify) , Puerto Rican	fes or No- n, etc.)	U.S.A. 14. Race - Ame Black, Whit Specify: whi	erican Indian, e, etc.
21215-0036	vithin 72 ho ne. han *natur e Medicel	mpleted	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)		(Give	ident's Usual Occu kind of work done DO NOT use retire	e during most ea)	t of working	16b.	Kind of Business	Industry
land 21	ld be filed w ental Hygiei ked other ti ic event, In	To Be Col	12 17. Father's Name (First, Middle, Last Ludwig Thiemann)		Secretary	18. Mothe	r's Name <i>(Fir</i> s 1Sta Me	t, Middle, Maide	raton Ma an Sumame)	nufacturing
, Maryland	and 2 should ealth and Men n 27 ie marke her traumatic		19a. Informant's Name/Relationship (Janet Amthor- dau	ghter	5000	ng Address (Stree Eugene A		Baltim			
Baltimore,	t. Pages 1 rtment of H rtant: If ite		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ 41☐ Donation 5 ☐ Other (Special Country)	Removal from State (fy)	cemetery, cre arkwood	osition (Name of matory or other plate) Cemeter	у	5/1/20	04 Ba		Maryland
Ba	permit. Departr Imports any inji		21. Signifure of Funeral Service Lice 23a. Parti Enter the disease, or com	ex.	6	415 Bela	ir Roa	d Balt	imore, l	I Funera Maryland	1 Home, Inc. 21206 Approximate
760,	Physician /Medical Examiner but such the physician and such the private the private that such th	dical Examiner	shock of heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.)	egal quay of):	(y					Interval Between Onset and Death
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	Ectopic pregnanc	Ç у			23d. Date of del Month	ivery Day Year
<u>a</u>	w requires that been signed by should be deta	þ	Part II. Other significant conditions of Receipt Ischer		sulting in the u	nderlying cause g	iven in Part I.	2	3e. Did tobacco		the cause of death?
Vital Records,		e Completed	Recent reciume with raction 25. Was case referred to medical	1	/	lying reatme			4a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 No
Division of Vi	ling Phys After this luneral di	To B	examiner? 1 Yes 2 Yeo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wo	her: 4 Nur	rsing Home 5		6 ☐ Other (Specury occurred	city)
Divis	s after des al Director ed in by th	Certification:	3 Suicide 6 Could not be determined		nome, farm, sti ify)	reet, factory, office		28f. Lc	ocation (Street a ity or Town, Stat	ind Number or Ru te)	ral Route Number,
1	To the Hospitel or Attending Ph within 24 hours atter death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only *2 Medical Examone)	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deat ation and/or in	vestigation, in my	opinion, deatl	d place, and du h occurred at t	the time, date ar	nd place, and due	to the cause(s)
)	Tot com	Σ	29b. Signature and title of certifier	rseum P	Atholog	29c. Licen	se number 35 7	04	29d. D.	ate signed (Month	n, Day, Year) 2004
	y	, l	30. Name and address of person who Hora P Larsen 31. Data filed (Month Paul York)	completed cause of death (Ite	m 23a) (Type,	Print)	ospit	al 56	ol Las	Raven	Blud
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 2004	32. Registrar's Sign	gure A	Day it					

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of	Marylar		artmen <i>rtificat</i>				lental H	ygiene Reg. No	200	4	13	368
	Physic	ian	Decedent's Name (First, Middle, I	.ast)					.		2. Date of D Month	Da		ar		of Death
1	/Medi	cal	EVA						3LU1		APRIL			<u> </u>	9.4	0 A . M
	Exami	ner	4a. Facility Name (If not institution, g John HOPKing					Town, or	Location	of Death		40	. County of (Death		
	Funeval					last birthday)			If Under	24 Hrs.	8. Date of B	irth	9	Birtho	lace (State	e or Foreign
н	Funeral Director		213-34-6815	1□M 2 X F	67	Yrs.	Months		Hours	Min.	8. Date of B (Month, D Jan. 4	ay, Year)	3.7 Ma	Cour	and	g of Toleigh
	P. J		Usual Residence of Decedent				1				Dani 4	, 1).	, FIG			
	arylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							1		City Limits
	he M	ecto	MD Baltim	ore	Woo	dstock										s 2XINo
	with with the or	급		1			10f. Zip						izen of Wha		•	
	Jeath	Funeral Director	3113 Hernwood Ro	12. Was Decede	ent Ever in U	.S. 13.		163 dent of Hi	ispanic Ori	igin? (Sp	ecify Yes or N		ed Sta			
9	or iter	표	1 ☐ Never Married 2 💢 Married	Armed Force	s?						ecify Yes or N Rican, etc.)		Black, V			
03	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes	2 <u>K</u> J No	Specify:				Specify:	Whi	te	
21215-0036	within 72 hours after death with the Maryland ene. than "neture!, or items 23e or 28e-f show its Madical Examitrast be notified at	Completed	15. Decedent's (Specify only highest of	Education trade completed)		(Give	dent's Usua kind of wo	rk done d	during mos	t of work	ing	16b. K	ind of Busin	ess/Ind	dustry	
121	within the the the the the the the the the the	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT us					_	1.0			
d 2	filed within Hygiene.		12 17. Father's Name (First, Middle, La.	st)		Resta	urant	Own		ar's Nam	e (First, Middle		d Serv	/1C	es	
an	d be ental ked o	To Be	Jesse E. Miller	,							Unknow		ourname,			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23e or 28e-f show other treumatic event, if a Madical Examiliar mast be notified at	1	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailii	ng Address	(Street a			al Route Numl		or Town, Sta	te, Zip	Code)	
	1 and 2 Health a tern 27 is		Thomas R. Blunt	Husba	and	3113	Hernw	rood	Road	Wo	odstock	, MD	2116	53		
Baltimore,			20a. Method of Disposition	□D01	20b. F	Place of Dispo	sition (Nan	ne of ther place	e) i		Date		ocation - City	or To	wn, State	
Ē	Pag nent ent: f		1 🎇 Burial 2 ☐ Cremation 3 '4 ☐ Domation 5 ☐ Other (Spec		110	nite P			1	4/30	/04	Woo	dstock	c. 1	ÆD.	
alt	permit. Pag Department Importent: any injury once.		21. Signature of Funeral Service Lic	ensee		22 R	2. Name an	d Addres	s of Facilit	ty Funo:	rol Dir					
ш	g Q E # 9		Jame 19	car	111	li	212 W	i. 01	d Li	pert	ral Dir y Rd.	Winf	ield,	MD	217	
Ш			2 Pa Enter the disease, or co shock, or heart failure. List on	mplications that causely one cause on each	sed the deat h line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory a	arrest,		1	Approxim Interval B	ate etween
,	Physician		/ Immediate Cause (Final dise se or condition sulting in death)	_a Sep	sis										Onset and	
	/Medical Examiner		and an addition	Due to (or	as a conseq	uence of):	, L.	ſ	. ba	1/1/1	nary trac	t in	Lostin	2	3 we	oks
		ا ا	Sequentially list conditions,	b. Pseul	as a consac	onal.	san	inge	ellon	, ~,	nary trac	9		_		
	uted d ansit	Examine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Chron	ie imr	nunos	ирри	esion	n d	ue	to st	enoi	ds		1 y e	ear
o,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):		,				······		+	1 y e	
8760,	ate be nysicii he bu	cai	•	d. Lilan	t ce	11 ar	rent	い 						-	Lye	
9	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:													
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1☐Live birth	2 Feta	Ideath 3□	Ectopic pr						23d. Date of Month		ry Day	Year
	ires that the de signed by the a 1 be detached	ysic	1 ☐ Yes 2 121No 9 ☐ Unknown	4☐Pregnan 9☐Unknowr		eath 5	Other (sp	өсту)							,	
P.0	that the ded by deta		Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco u	se contribut	e to the	e cause of	death?
rds	quires n sign	d by	Myopathy, coron	vary artery	dis	ease, e	SOPL	ageal	Cana	lida,	1 🗆	Yes 2]No 3[] Proba	ably 4	2Unknown
00	aw require ts been si 2 should b	olete	seizunes, left he	nispheric i	vater.	shed s	Stocke	, Ac	stick	ralve	24a. Was	an	24b. Were	autop	sy finding	s available
R	The late ha	Completed	replacement on ch	ronic anti	eragu	lation	, Acu	te re	nal fo	ailur	auto perfe 1 ☐ Yes	psy ormed? 2 ⊠ No	prior death	1?	ıpletion of 2□ No	cause of
ital	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?								(Check only					
) V	S 5	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpa	atient 2 🗆	ER/Outpatien	it 3□ DO	A Othe	r: 4□Nu	rsing Ho	me 5 Resi	idence (3 □Other (S	specify,)	
n	ding Ph .r After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, a	njury Day Year)	28b. Time of Injury		8c. Injury Work	at ?	- 1	28d. Describe					
Sio	Attending r death. sector: Atterby the fune	cat	2 Accident investigate 3 Suicide 6 Could not	ha	1.5		М		′es 2 🔲 i		201 1	· ·				
Division of Vital Records,	l or Atten after deat Director:	Certification:	4 Homicide determine	d 286. Place of	etc. (Specify	me, fam, str /)	eet, factory	, office			28f. Location (City or To			Rural	Route Nu	mber,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a, Certifier 1 Certifying F	Physician: To the be	st of my kno	wledge death	occurred :	at the tim	e date an	d place	and due to the	cause(s)	and manner	ae ets	uted.	
	e Hoo	edical		miner: On the basis and manner	of examina	tion and/or in	estigation,	in my op	inion, deat	th occurr	ed at the time,	date and	place, and	due to	the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c	. License	number				e signed (Me			
	~)		Annie Thomas	M.D.			A	RES.	-00	0		Ap-	ril 2	6,	200	4
	1,3		30. Name and address of person who	completed cause of	f death (Item	23a) (Type,	Print)		L 1 4	انمه	intolda C	L D-	Itimo	2 A	10-2	1787
	`		Annie S. Thomas, Depar				opkina	HOSPI	rat, o	- N.	-4013871	190	CITIMO:	-, /	. J d	- ~ ~ 7
	Sta Registi		31. Date filed (Month, Day, Year)		strar's Signa	ture	boor	1 -1500-								
	riogiali		APR 2 8 200	4 Vada Valan	-	14	appara	12.18	1							

DHMH 17 Rev 1/2001

ORIGINAL

			State	of Maryland / Depart			•	_	
			1 - State Registrar	-	rtificate of		Reg.	- 21111.	13369
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
3	/Medic Examin	al	Mary Anna Butt 4a. Facility Name (If not institution, give street and i	number)	4b. City, Town, o	r Location of Death	April 27		3:05 am M
			Gilchrist Center for Ho		Towson	1 1611-4-10411-1		Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☒ F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 10/28/19		hplace (State or Foreign untry) Vland
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Man ta-f sh	ctor	Pennsylvania York	Stewartst	own				1 ☐ Yes 2 X No
	with th	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?
	leath v	Funeral	151 Grove Road 11. Marital Status 12. Was Di	ecedent Ever in U.S. 13.	17363 Was Decedent of H	ispanic Origin? (Spe	U.	S. A. 14. Race - Amer	rican Indian
9	after d or Iten	Fun	1 Never Married 2 Married 1 Ye	Forces?		lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White	
903	hours ural',	d by		Dates:	1 ☐ Yes 2 ☐ No	Specify:			nite
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. By other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified.	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give	dent's Usuaf Occup kind of work done of DO NOT use retired	ation during most of worki d)	ng 16t	o. Kind of Business/l	ndustry
212	od with giene. er tha	E O	Elementary/Secondary (0-12) College	(1-40/5+)	ierer		İ	Electronic	CS_
Maryland	be filed that Hygie of other the event, It	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Mai	den Surname)	
	2 should be and Menta Is marked sumatic ev	P	Webster Elsworth Jone 19a. Informant's Name/Relationship (Type, Print)		ng Address (Street		ertrude Number Ci	Nestor ty or Town, State, Z	in Code)
	# 53 m			1	Colvilla			. Marylar	
Baltimore,	0 0		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal fro	20b. Place of Dispo			ate 200	Location - City or 1	
Ĭ	Ly and Pa		`4 ☐Donation 5 ☐ Other (Specify)	Holly Hi	ll Mem. C	ard. 200		altimore,	Maryland
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	l B	Name and Address	ci Funeral	Home PA		1 21221
		-	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of	t caused the death. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arrest,	sex, Mary	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition		1 con	ncer			Onset and Death
	/Medical Examiner		resulting in death) Due	o (or as a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as a consequence of):					
/	be executed ician and burial-transit	Examiner	that initiated events c.	,					
760,	ate be executed nysician and he burial-transit	cal Ex	Due	o (or as a consequence of):					
9	ifficate g phys as the		d.						
Box	death certifica e attending ph id for use as th	an/M		outcome of pregnancy	Ectopic pregnancy			23d. Date of deliv	
o i	the dea y the al	Physiclan/Med	1		Other (specify)			Month	Day Year
S,	res that the de signed by the a l be detached f	by Pr	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause give	en in Part I.	23e, Did tobacc	co use contribute to	the cause of death?
ord	w require been si						1 🗌 Yes	2No 3□Pro	bably 4 Unknown
Records,	e la has	Completed					24a. Was an autopsy performed	? prior to co	opsy findings available ompletion of cause of
Vital		a	25. Was case referred to medical			26. Place of Death	(Check only one)	No 1 Yes	2□ No
ot <	Physician: this certific ral director,	To B		Inpatient 2 ER/Outpatier		er: 4 🗆 Nursing Hon	ne 5 🗌 Residence	1.5	in Hospice
ono	ding F. h. After funera	tlon:	1 Natural 5 ☐ Pending (M	e of Injury 28b. Time of Injury Injury	Work	/ at 2 <br Yes 2 □ No	28d. Describe how in	njury occurred	
Division	Atten deal ctor: y the	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pla	ce of Injury - At home, farm, str			28f. Location (Street	and Number or Rur	al Route Number,
ā	ital or A irs after ral Direc led in by		# [] Liouncide Dri	ding, etc. (Specify)			City or Town, St	ate)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the and many one)	he best of my knowledge, death basis of examination and/or in Inner stated.	n occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cause ad at the time, date	e(s) and manner as and place, and due t	stated. to the cause(s)
	To the Comp	×	29b. Signature and title of certifier	1-0	29c. License	number	29d.	Date signed (Month,	
•	di		30. Name and address of person who completed ca	use of death (from 23a) (Type,	Print)	0 200	2.		7, 2004
	1,3		W.A.Riley GBU	nc 6701 1	X. Charl	est-Pal	to md	20207	
	Sta Registra		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	from so				
			APR 6 0 / 1114 /	18	The said of the said				

DHMH 17 Rev 1/2001

Butt, MARY

3:05 Am

4-27-04

			For State Registrar	State of Maryla	nd / Depa		Health and	d Mental Hy	giene 2004	13370
			Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
	Physici /Media		John T. Birch, S	r.				April	Day Year 24 2004	8:30 A ^M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of De		4c. County of Death	10:00 //
			2 McArthur Court			Cockeys			Baltimore	e
	Funeral		5. Social Security Number 6. Se	RM 2□F	. last birthday) Yrs.	If Under 1 Year Months Days		lin. (Month, Da	y, Year) Coui	place (State or Foreign
	Director		212-20-6833 Usual Residence of Decedent	78	113.			Nov. 2	0, 1925 Mai	yland
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation				Od. Inside City Limits
	B-fsl	ctor	MD Baltimor	e Coc	keysvi.	lle				1 ☐ Yes 2 No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cour	ntry?
	s 23a	rai	2 McArthur Court	Apt. E		21030			USA	
	ltems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
36	urs aff	by F	3 ⊋Widowed 4 □Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify:	
9-0	72 hours after death with the Maryland netural', or Items 23a or 28a-f show dical Examinet must be invitted at	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	upation	,	นไว้ 16b. Kind of Business/In	
215	within 7 ene. than "r	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	e during most of i red)	working		
2	be filed within 72 hours after death with the Marylar Ital Hyglene. In other than "netural", or Items 23a or 28a-f show event, the Medical Exambre to ust be published at		12		Offic	e Admini			Railroad	
and		Be	17. Father's Name (First, Middle, Last)	1_				lame (First, Middle,		
Maryland 21215-0036	d 2 should the and Ment 7 is marked treumatic	2	Peter Richard Bird 19a. Informant's Name/Relationship (T)		19h Mailie	ng Address (Stree	Cather		cker r, City or Town, State, Zip	Code
	122 7 a 7		John T. Birch, Jr			rthur Co				
re,	- I 9 =		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pla		Date	Keysville M 20c. Location - City or To	wn, State
E	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ F '4 ☐ Donation 5 ☑ 9ther (Specify)	ternoval from State	•	Service (· 1	26/04	Towson, MD	
Baltimore,	permit. Pag Deportment Important: I any njury o		21. Signature of Fune at Se Al Moons		1	. Name and Addr			1050 York	Road
<u>-</u>	89589		Machon y to	who		ick Towso			Towson. MD	
П			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the dea ne caus on each line.	th. Do not ent	er the mode of dy	ring, such as card	liac or respiratory ar	rest,	Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition resulting in death)	Kestrie	ilon i	anest	lin	metar	topes	Onset and Death
	/Medical Examiner		resulting in dealth)	Day to (or is a conse	quence of).	10.0	1	MARIANI		2 М
		er	Sequentially list conditions,	Due to (or as a conse	quence of it.	uc v	ma c	will.		311
k	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,					
Ó	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):		\bigcirc			
3760,	× × =	icai		d						
68	death certificate e attending phy ed for use as the	Physician/Med	IF FEMALE:							
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Fet	al death 3	Ectopic pregnanc	су		23d. Date of deliver	ny Day Year
0		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of of 9□ Unknown	death 5∟	Other (specify) _				Say Tour
а.			Part Other significant conditions con	ntributing to death but not res	sulting in the u	ndertving cause gr	ven in Part I.	23e. Did to	bacco use contribute to th	e cause of death?
Records,	w requires been sign should be	ed by	Done, liver	, My D	nevor	reses		Χ̈́Υ	es 2 □No 3 □ Prob	ably 4 □Unknown
CO	s been 2 shoul	piete	No Treaticulos	6		Ť		24a. Was a	n 24b. Were auto	osy findings available
Ä	0 5 0	Completed	Corimor outs	in disease	0 /			- autop: perfor 1 ☐ Yes	rged? prior to cor death? 2 k No 1 ☐ Yes	npletion of cause of
Vital	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of D	eath (Check only or		20.10
of <	S 5	은	1 □ Yes	1] ER/Outpatien	, all box		Home Reside	ence 6 ☐Other (Specify	')
	ding P	inol	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		ork?	28d. escribe h	ow injury occurred	
Division	Attending r death. sctor: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm str]Yes 2□No	28f Location (S	treet and Number or Rura.	I Pouto Number
<u>≥</u>	after Dire	Certification:	4 Homicide determined	building, etc. (Speci	fy)	set, lactory, office		City or Town	n, State)	rnoule ivambel,
	spite hours meral y filled		29a. Certifying Physical Certification	sician: To the best of my know	owledge, death	occurred at the ti	ime, date and pla	ce, and due to the c	ause(s) and manner as st	ated.
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my	opinion, death oc	curred at the time, d	ate and place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and time of certifier	NUIA/		29c. Licen.	se number) 2	9d. Date signed (Month, I	Day, Year)
}	1.1		I www man	JUNU			48/60	/	412410	4
1	441		30. Name and address of person who co	empleted cause of death (Iter	m 23a) (Type,	Print)	CLADO	R.H	The state of the s	21201
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature C	neme	inece	, Dall	more us -	21201
p.	Registr		APR 2 8 2004	General 19	200	Kal	,		,	

		Fa.	Plea	se Type or State			Black Ind d / Depa					•		_	le.	
		1 - For State Registrar				•				Death				. 20	04	13371
Physici	an	1. Decedent's Nam		e, Last)								2. Date of D		ay	Year	3. Time of Death
/Medic			lina		uso							April	27,	2004		10:10 aM
Examin	er	4a. Facility Name (i		n, give street and n	u <i>mber)</i>					Location	of Death		4	c. County o		
Funeral		5. Social Security N		6. Sex	7. Ag	e (In yrs. la	ast birthday)		WSON r 1 Year	If Under	24 Hrs.	8. Date of B	irth	Balti		
Director		219-10-3	304	1□M 2√1F	7.9		Yrs.	Months	Days	Hours	Min.	Dec. 5	,192	24	Mary	lace (State or Foreign try) land
yland		10a. State	10b. County			10c. City	, Town or Lo	cation							1	0d. Inside City Limits
e Mar	ctor	Maryland	N/A			Ba	ltimor	e.								1 Ves 2 □ No
or 26	Dire	10e. Street and Nu						10f. Zi	Code			-	10g. C	itizen of Wi	nat Cour	try?
s 23a	Fral		oston	Street Un		-	2 140 14		224		0./0	" \		USA		
fter de r item iner.	Funeral Director	11. Marital Status 1 ☐ Never Marr	ied 2.X⊓Mar	12. Was Ded Armed F ried 1 ☐ Yes	orces?		5. 13. V	Yes, spe	cify Cuba	in, Mexicai	n, Puerto	cify Yes or N Rican, etc.)	0-	14. Race Black,	White,	
ret', or	by	3 ☐ Widowed	,,	If Yes G	ive Dates:		1	☐ Yes	21X No	Specify:				Specify:	Wh	ite
72 hc 'netu	etec	(Spec		t's Education st grade completed)		16a. Deced	lent's Usu	al Occupa	ation during mos	t of worki	ng	16b.	Kind of Bus	iness/Ind	lustry
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time X7 is marked other then "neturer", or items 23a or 28e-f show eny injury or other treumetic event, if a Madical Examinar must be notified.	Completed	Elementary/Seco	ondary (0-12)	College	(1-4or 5	+)	Home)			Ow	n Hom	e	
al Hyg	Bec	17. Father's Name		•								(First, Middle	e, Maide	n Sumame,)	
ould b Ment Marked	To	Frank	Gottu							Cath				ello		
12 sh h and 7 is m treum		19a. Informant's N			لممدم							/ Route Numi				
1 and Healt em 2		Mr. Georg 20a. Method of Dis		ruso/Husb	ana	20b. Pla	2515 ace of Dispos metery, crem	BOST sition (Na	on Same of	treet		5 Balt		e Mai		nd 21224
ages ant of ht: If if		1 Burial 2	Cremation	3 □Removal from Specify Entomb l	State		_{metery, crem} aney V				/30/	14				ryland
mit. F partme portar r injur		21. Signature of Fu			nen t	/				s of Facilit		J-T	4 1 411			k Road
permi Depar Impo eny ir		m	chase	11 Rue	1		Ru	ck T	owsor	1 Fun	eral	Home,	Inc	Tows	on M	d.21204
		23a. Part1. Enter t shock, or hea	he disease, ou art failure. List	complications that only one cause on	caused each lin	the death.	. Do not ente	or the mo	te of dying	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between
Physician		Immediate Cause disease or condition	(Final	a M	et	AST	atic		mo	eR	010	ink	Oce)11	ļ	Onset and Death
/Medical Examiner		resulting in death)		Due to	(or as	a consequ	ence of):) (ma	14	X (e	ink				Morri
	-e	Sequentially list co	nditions,	b. —— Due to	(or as a	a conseque						/				
uted	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	erlying injury	S .			,									
	Exa	resulting in death)		Due to	(or as a	a conseque	ence of):									
death certificate be attending physicia for use as the bu	edical			d												
The law requires that the death certificate b tee has been signed by the attending physic bage 2 should be detached for use as the b	Mec	IF FEMALE:		23c. If yes, ou	taama	of program										
attend for us	cian/M	23b. Was deceden in the past 12	months?	1 Live	birth	2 ☐ Fetal of dea	death 3 □	Ectopic p						23d. Date of Month		y Day Year
that the dead by the detached	Physici	1 ☐ Yes 2 9 ☐ Unknown	S No	9□ Unkr		01 001	0	01101 (3)	outy)							
res that signed t	by P	Part II. Other signif	icant condition	ons contributing to c	death bu	at not resul	lting in the un	derlying o	ause give	n in Part I.		23e. Did	tobacco	use contrib	ute to the	e cause of death?
v require been sig should b		Dein	enti			1						1 🗆	Yes 2	50 00 3	☐ Proba	bly 4 □Unknown
e law re has be	ompleted	mit	rxl	VALUE	d	130	015C	Sh	rtus	1005	T	24a. Was		24b. We	re autop	sy findings available ipletion of cause of
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ysicien: Th	Be	25. Was case refer examiner?		Hospital:					Otha	_		Check only				
Phys this aldi	To	1 Yes 2	V	28a. Date			R/Outpatient 28b. Time of			4 LI NU		ne 5 Res			(Specify,	Hospia
ding th. : Afte	itlon	1 Natural 2 Accident	5 Pendin	g (Mor	ith, Day	Year)	Injury	м .	8c. Injury Work 1 ☐ Y	? ∕es 2 ∐ i			now inju	ny occurred		
Atter er dea ector by the	Certification	3 Suicide	6 Could determ	not be 28e. Place	e of Inju	iry - At hon	ne, farm, stre	et, factor	, office		2	8f. Location (Street a	nd Number	or Rural	Route Number,
itel or rs afte al Dir	Cert	4 Li Homicido		Dullo	iing, etc	:."(Specify)						City or To	wn, State	θ)		
To the Hospitel or Atlending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)	1 Certifyin 2 ☐ Medical	g Physician: To the Exeminer: On the b and man	pasis of	examination	rledge, death on and/or inve	occurred estigation	at the tim , in my op	e, date and inion, deat	d place, a th occurre	nd due to the d at the time,	cause(s date an) and mann d place, and	er as sta due to	ted. the cause(s)
To the within To the compl	Me	29b. Signature and	title of gertifie	. 1	1	7			License				29d. Da	ite signed (/	Month, D	Pay, Year)
1		1	that	hong K	el	m,	and) I	25	20.	5		Api	ril e	27,	2006
V		30. Name and addr	ess of person	who completed cau	se of de	ath (Item :		Print)	Ga	lo	(+	Qui	245	mal	2	2006
Sta		31. Date filed (Mon	the Day, Year)	/		r's Signatu		/		>	<u> </u>	7-0	70	104		
Registra	ar	131 11	701	2.5		1	so the	OOLA	2/							

State of Maryland / Department of Health and Mental Hygiene 2001

13372 AMEND ITEM #20b PER FH C830 2/28/04 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAMES BASS APRIL 23 1400 /Medical 4c. County of Death 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE NIA BLUE POINT NURSING HOME If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days 1⊠M 2□ F 25 03 8314 96 Yrs. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Madical Examiner must be notified at NIA BALTIMORE 1 XYes 2 No MD Director 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? FAIRVIEW AVENUE 21216 40D3 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 Specify: BLACK 1 Yes 2 No Specify: ۵ 3 X.Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL STEELWORKER 1+h arade 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental HONRY BASS LIZZIE TYNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau MAYERS 4003 FAIRVIEW AVENUE BALTIMORE MID LIFTON 20b. Place of Disposition (Name of cemetery, crematory or other place) 4/28/04 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT CREMATORY OF 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
CREMATION SERVICES 21229 SISI BALTIMORE NATIONAL an PIKE BALTIMORE MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear-failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Thorus Immediate Cause (Final disease or condition resulting in death) /Medical . END STAGE VASCUUM DEMENTIA Examiner Due to (or as a consequence of): by Physician/Medical Examiner SUPRINSELLIAR MASS The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieled events resulting in deeth) Last Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Enknown of Vital Records, 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No this 24 hours eftar deeth.
Funeral Director: After thi etaly filled in by the funaral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 hou To the Fune completely fil 29c. License number 29d. Date signed (Month, Day, Year) H4S931 who completed cause of death (Item 23a) (Type, Print) BATIMONE MD 21208 7220 PANK ITEIGITS AVENUE \$2. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of	Maryland /		artment rtificate					Reg. No.	200		13374
	Physici		1. Decedent's Name (First, Middle, I								2. Date of Dea		4 Yee		Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, 9						Location of			4c. (County of De		<i>'</i>
	Funeral Director		5. Social Security Number 213-30-310	.Sex 7. 1 ☐ M 2 ☐ № 7.	Age (In yrs. last t	oirthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 03-05	y Yeer) 9 – 33	9. 8	Sirthplace Country) VIRC	GINIA
	Maryland -f show	tor	Usual Residence of Decedent 10a. State MD . 10b. County		10c. City, To	wn or Lo									Inside City Limits 1 □ Xes 2 □ No
	sa or 28a	I Direc	10e. Street and Number 1334 HICKOR	Y SPRING	S CIR.		10f. Zip 2	Code 1228	8			10g. Citiz U	en of What (Country?	,
5-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or items 23a or 28a-f show svent, the Medical Examinar must be multified at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 Tyes 2 If Yes, Give Year or Date	es?	1	Was Deced f Yes, spec	ify Cubai	spanic Ori n, Mexican Specify:	gin? (Spe	cify Yes or No- Rican, etc.)		4. Race - An Black, Wh Specify: B	nite, etc.	,
21215-(e filed within 72 h al Hygiene. I other than "natu vent, the Wedlea	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)			(Give life. L	dent's Usua kind of wor DO NOT us MEMA	k done d e retired,	lurina mosi	t of worki	ng		MEST		ry
Maryland		To Be C	17. Father's Name (First, Middle, La HENRY HODGE	st)							(First, Middle, GREEN]		Sumame)		
	nd 2 shatth and 27 is m		19a. Informant's Name/Relationship VALERIA GAI!	(Type, Print) PHER DA	UGHTER						NGS C				^{de)} ID.21228
altimore,	permit. Pages 1 ar Department of Hea Important: If Item any injury or othe OUCE.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of				sition (Nam natory or ot WN C				ate -27-04		ation - City of		Stete
Balt	permit. Depart Import any inj	100	21. Signature of Fune al Service Lic	onsee Inc	Seft.	22	. Name and	Addres	s of Facilit BERT	Y HOW Y HO	ELL FU	UNER AVE.	AL HO	OME CO.	MD.2120
¥	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Car cu	sed the death. Do	7 the				cardiac o	r respiratory are	rest,		Inte	proximate erval Between set and Death
760,	te be executed ysician and le burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence										
.O. Box 68	death certificate e attending phy: id for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™ No 9 □ Unknown		h 2 Fetel deat at at time of death		Ectopic pre		-			23	3d. Date of d	elivery Day	/ Year
rds, P	as the gned	by	Part II. Other significant conditions HyperTensum		th but not resulting	in the ur	nderlying ca	use give	n in Part I.		23e. Did to				ause of death?
I Records,	The ate h page	Completed	Degeneration	re art.	hritra						24a. Was a autops perfor	sy	prior to death?	comple	findings available ition of cause of
Vita	Phyalcian: r this certilic ral director,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Inp	atient 2 ER/O	outpatien	t 3 🗆 DO/	Othe			(Check only or		Other (So	ec(fy)	
Division of	Attending r death. ector: After by the fune	Certification: 1	27. Manner of Death 1	28a. Date of (Month,		Time of Injury	28 M	lc. Injury Work 1 🗆 Y	at	No 2	8d. Describe h	ow injury	occurred		ute Number,
ă	pita nurs eral		29a. Certifier 1 (P Certifying I	hysician: To the beariner: On the basi	est of my knowledg	e. death	occurred a	t the time	e, date and	d place, a	City or Town	ause(s) a	and manner a	as stated	l.
/	To the Hos within 24 ho To the Fun completely i	Medical	29b. Signature and title of certifier	and manner	r stated.			License	number	,		29d. Date	signed (Mor		
1	2		30. Name and address of person wh	o completed cause			Print) A	D:	3016	2 A	6/2121	4/2	-/	. < 1	Fairchild
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	t. Sule		look.	au au	CPICV B	Hamilton IF	प्राची	VI	uniu	3.1	airania
-38	riegisti	ai	APR 2 8 2004	Alapa		JEST	A. Barrison								

			For State Registrar	State of Mar			of Health an of Death		Reg. No.	3. Time of Death
В	Physicia		1. Decedent's Name (First, Middle, Last)	Dwarm				2. Date of De Month	Day	Year 20° PM
	/Medic	al	Marian Siphonia 4a. Fecility Name (If not institution, give			4b. City, To	own, or Location of C	Death Death	4c. County	
1	Examin	er	Sinai Hospital	- 0	timore	Bal	timore C	city		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	If Under 1	Year If Under 24	Hrs 0 Date of Bir	h y, Year)	Birthplece (State or Foreign Country)
- 10	Director		217-74-6717	M 2∏F 9	6 Yrs.			Min. (Month, Da 03/17/	1908	Pennsylvania
	and w	}	Usuel Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
	Maryl f sho	ţō	Maryland Baltimo	re	Owings M	lills				1 ☐ Yes 2 No
	h the or 28a	irec	10e. Street and Number			10f. Zip C	Code		10g. Citizen of W	/hat Country?
	23a c	alD	4 Stonemark Court			211			U.S.A.	
	ar dea	nue	T. Maria Olaro	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Deceder	nt of Hispanic Origin y Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	Black	e - American Indian, k, White, etc.
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 Yes 2	Xno Specify:		Specity.	Black
21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. od other than "natural", or items 23a or 28a-f show event, the Mudical Examiner must be notified at	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	edent's Usual	Occupation done during most o	of working	16b. Kind of Bu	usiness/Industry
215	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)			1
21	filed with Hygien sther the		8 17. Father's Name (First, Middle, Last)		поц	sewife		s Name (First, Middle	Homema	
auc	should be filed within and Mental Hygiene. marked other than imatic event, the Mental than the) Be	William Pearson					Johnson		
Maryland	ges 1 and 2 should it of Health and Menrit It Item 27 is marke or other traumatic.	ဥ	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mail	ing Address (Street and Number	or Rural Route Numb	er, City or Town,	State, Zip Code)
	1 and 2 s Health ar tem 27 is		Hannah Sawyer / Da	ughter						yland 21117
ore	of Head of Head	. /	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of Disp cemetery, cre			4/29%2004		City or Town, State
Ë	. Pag tment tent:		4 □Donation 5 □ Other (Specify)	_	Maryland					Maryland es F/H, P.A.
Baltimore,	permit. Pages. Department of P importent: if Ite eny injury or of		21 Signature of Funeral Service Licens	· /-	46	511 Par	k Hgts. A	Ave., Balt	imore, M	laryland 21215
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence of):	A			rrest,	Approximate Interval Between Onset and Death 3 days
1760,	ite be executed ysician and he burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (u. as'9'	consequence of):	. Itec	art F	ATTOTE		J YEARS
.O. Box 68	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	□Ectopic pre	* /		23d. Dat Mor	te of delivery nth Day Year
Ω.	uires that signed b Id be deta	by	Part II. Other significant conditions co		_	underlying ca	use given in Part I.	23e. Did		ribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Records,	e law requir has been si ge 2 should I	Completed						24a. Was auto perfe	psy ormed?	Were autopsy findings available prior to completion of cause of death?
Vital		ဝင္ပ	25. Was case referred to medical				26 Place o	1 ☐ Yes		1 ☐ Yes 2 ☐ No
Ž	Physician: this certific ral director.	0 8	examiner?	Hospital: 1 Impatien	t 2 ER/Outpatie	ent 3 DOA	Other	sing Home 5 Res		er (Specify)
on of	Jing After fune	tlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	of 28	lc. Injury at Work? 1 □ Yes 2 □ No		how injury occurr	red
Division	of or Attendiated or after death. I Director: A in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	treet, factory,	office		Street and Numb wn, State)	per or Rural Route Number,
	To the Hospitel or Attent within 24 hours after dealt To the Euneral Director: completely filled in by the	Medical C	29a. Certifier 1 Gertifying Phy (Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner stat	examination and/or	ath occurred a investigation,	it the time, date and in my opinion, death	place, and due to the occurred at the time	cause(s) and ma date and place, a	anner as stated. and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	/			License number		29d. Date signed	d (Month, Day, Year)
			1/0-/1	~		K	25-C	000	April	22 2004
	(1)		30. Name and address of person who o	ompleted cause of de	ath (Item 23a) (Type	e, Print)	11	0 1 /	FO	11.
	V		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	. 31	NAI H	0501141	0 , [)al timens
1	St Regist	ate rar	0.000	2004	to a total	Societ.	· -			

DHMH 17 Rev 1/2001

MARION BROWN

		1 - For State Registrar	State of Marylan			t of Health an e of Death		R	eg. No.	2004	13376
Physici	an	Decedent's Name (First, Middle, Last	st)	n				Date of Deat Month April	Day 24	2004	3. Time of Death 5:15 a. M
/Medic		Vincent 4a. Facility Name (If not institution, give	e street and number)		utta 4b. City.	Town, or Location of D	_	ubrii	7	unty of Death	J.1J a.
Examin	er	Stella Maris				Timonium			Ba	1timor	e
Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. 80	last birthday) Yrs.	If Unde Months	1 Year If Under 24 Days Hours	Hrs. 8. Min.	Date of Birth (Month, Day, pril 1		G 0:45	lana (Charles as Francisco
Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County Manual and Deltimes		y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the 28a-	rect	Maryland Baltimo	re	TOWSOLI	10f. Zij	Code		1	0g. Citizen	of What Cou	ntry?
3a ol		318 Apt. A5 Ste	evenson Lane			21204			U.S.	4.	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show eumatic event, the Medical Examinational be notified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 □ No WW If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Tyes	dent of Hispanic Origin cify Cuban, Mexican, F 2 No Specify:	n? (Specifi Puerto Ric	y Yes or No- an, etc.)		Race - Ameri Black, White, ecity: Whi	
2 hou		15. Decedent's Ed		16a. Dece	dent's Usu	al Occupation ink done during most of	f working		16b. Kind	of Business/In	
d within 7 giene. er then "n	Completed	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT L	Conductor	i working		Rat	ilroad	
uld be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last, Philip	Butta			18. Mother's Jeni		irst, Middle, I	Meiden Sur	LaPort	τ
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Madical Examinational be notified at QDCS.		19a. Informant's Name/Relationship (Mrs. Mary Butta 20a. Method of Disposition 1 \(\overline{\text{2}}\) Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of the control of the cont	(wife)	318 A	Apt. position (Namatory or	me of	ison Date	Lane	Towso		land 21204 own, State
permit. P Departme Importen eny injury		21. Sign tup of Funeral Service Licer				of Figure 500 York Koa		_			ISIKI
Death certificate be executed (Madical Examiner) and for use as the burial-transit	Ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. COLON CANC Due to (or as a conseq b. Due to (or as a conseq c. Due to (or as a conseq d.	uence of): uence of):							Inierval Between Onset and Death
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	∃Ectopic p ∃ Other (s				23d	Date of deliv	ery Day Year
uires that t signed by Id be detac	by	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	inderlying	cause given in Part I.					he cause of death?
The lay ate has page 2	Completed						_	24a. Was a autops periori	ned? ∑XNo	4b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of 2 No
ng Phys fter this meral dir	cation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time o Injury		Other	ing Home	5 Reside	ence 6 X		y) HOSPICE
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certifica	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At h building, etc. (Specif	ome, farm, st y)	reet, facto	y, office	28f	Location (Si City or Town		umber or Run	al Route Number,
To the Hospital or within 24 hours afte to the Funeral Discompletely filted in	edical		nysician: To the best of my knominer: On the basis of examina and manner stated.		vestigation	n, in my opinion, death		at the time, d	ate and pla	ce, and due t	o the cause(s)
To the To the Complex	Σ	29b. Signature and title of certifier) =		29	c. License number	5	2	9d. Date si	gned (Month,	Dey, Year)
4		30. Name and address of person who DR. TARIQ MAHMO	OD 2300 DULANI	EY VAL		D. TIMONI	UM, 1	D 210	93		
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar Signa		· Con	will					

5:15 а.ш.

APRIL 24, 2004

VINCENT BUTTA

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JOOL Jacqueline Boan /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Y 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number **Funeral** Days Hours Months 1□M 2**∑**F 70 219-28-1586 August 4, 1933 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23s or 28s-f ehow enty injury or other traumatic event, the Modical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No Baltimore Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8921 Mavis Avenue 21236 u.s.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Thomas Clara Sain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8921 Mavis Avenue, Baltimore, MD 21236 Mr. Robert Boan (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4/28/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Years Iwo /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Examiner Due to (or as a consequence of): il or Attending Physicien: The law requires that the death certificate be executed after death.

Director: Atter this certificate has been signed by the attending physician and Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed? (es 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C tha Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number completed cause of death Item 23a) (Type, Print) Baltimore MD 21237 guare leininger. 22. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 8 2004

DHMH 17 Rev 1/200

Registrar

Joe avelin

P.O. Box 68760.

			1 - For State Registrar Amend it ou	State of Marylan					giene	200	4 13378
1	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution; give s	treet and number)		E	AS H or Location of Death	2. Date of Dea Amonth April	Day	Year 200 County of Dea	3. Time of Death 19.419 M
, k	Funeral Director		5. Social Security Number 550-12-9472 Usual Residence of Decedent	7. Age (In yrs. 82		f Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	10/ 2	8/21 ^{9. Bit}	rthplace (State or Foreign ountry) NIO
	e Maryland Ba-f show	ctor	10a. State 10b. County NV Clark		y, Town or Locat Las Vega	S					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 21	Funeral Director	10e. Street and Number 550 Oakmount Aven	ue, Apt. 17		10f. Zip Code 8 91 0	9		10g. Citiz US	en of What C A	ountry?
920	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Maulcal Evaminer must be maillfish at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 5 Yes 2 □ No If Yes, Give Year or Dates: WWII	If Ye	s Decedent of Hes, specify Cub	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		4. Race - Am Black, Whi Specify: W	
21215-0036	d within 72 ho piene. r than "natur the Mexical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give kını	NOT use retire	during most of world		Unit	ed Sta Force	•
aryland?	should be filad and Mental Hygis a marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Dewey Sampson Bas 19a. Informant's Name/Relationship (Type)		10h Mailine A	Address (Strass	18. Mother's Nam Grace N and Number or Ru.	Matilda (Smit	า	Ti- Code)
≥	1 and 2 Health a am 27 is ther tra		Lily M. Bash - wif	e 20b. P	_	ewland	Road, Par		CA	95969 cation - City or	
Baltimore,	permit. Pages Department of I Important: If its eny injury or o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Litens	(the	esapeake C CAF	ame and Addre	4/28/ hen D. Lo Pastures			sville	
1000	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat	h. Do not enter the	he mode of dying	ng, such as cardiac	or respiratory ari	rest,	SO11, PI	Approximate Interval Between Inset and Death
1760,	Ite be executed the best of th	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a coaseq Due to (or as a conseq	enia	- gr	avis				6months 5years
.O. Box 68	To the Hospidal or Attending Physician: The law requires that the death certificate be executed within 24 hou's after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funaral director, page 2 should be detached for use as the burial-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3□Ec	topic pregnanc	ý		2	3d. Date of de Month	livery Day Year
S, D	w requires that been signed by should be deta		Part II. Other significant conditions con	tributing to death but not res	ulting in the unde	rlying cause gr	en in Part I.	23e. Did to	Α.	1	o the cause of death?
al Record	n: The law re licate has be r, page 2 shu	Completed							sy med? 2 🗆 No	24b. Were as prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
on of Vital	To the Hospidal or Attending Physician: The law within 24 houly after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	tlon; To Be	27. Manner of Death 1 Natural 5 Pending	ospital: 1 X Inpatient 2 2 28a. D te of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injui Wo	y at	th (Check only or ome 5 Resid 28d. Describe h	ence 6		ocity)
Division of	after deat Director:	Certification:	Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street,			28f. Location (S City or Tow		Number or R	ural Route Number,
	To the Hospidal or Attending I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death oc tion and/or invest	curred at the til tigation, in my c	me, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) a late and	and manner as place, and due	s stated. e to the cause(s)
	S S S S S S S S S S S S S S S S S S S	M	29b. Signature and title of certifier mo			29c. Licens				signed (Mont	
(30. Name and a cross of person who cor James Castle	mpleted cause of death (Item	23a) (Type, Prin	H WOLF	c Street	, Barti	TYIDI	e MD	2/287
6	Sta Registi		31. Date filed (Month, Day, Year) APR 2 8 200	32. Registrar's Signa	iture 4	lond			-3		The state of the s

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ralph Anthony Breckenridge APRIL 2004 5:45 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**∑**M 2□ F Director 579-18-6614 82 Mar 7. DC 1922 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with John Ellicott Court 8604 21043 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: ₩₩∏] 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married ME KNOWN TO PHYSICIAN: Bi Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ρ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental Breckenridge Maurice L. Amv Ε. Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 1s any injury or other treu 8604 John Ellicott Ct., Ellicott City, MD Helen Breckenridge - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 4/27/2004 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Yowson, MD Steven H. Williams M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) CANCER OF ESOPHAGUS **Physician** UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ※☐Unknown Completed 24a. Was an cate has to this certificate 1 ☐ Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funerel I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D52739 APRIL 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sparkers Registrar APR 2 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

RALPH

BRECKINRIDGE,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2001 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 26--cLa 04 4:35 AM Bair /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis-Long Green Center Baltimore If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Yrs. Director 213-18-3041 94 March 25,1910 West Virginia Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Heelth and Mental Hygiene. ant: If Itam 27 is marked other than "natural", or itams 23s or 28s-f show ury or other traumetic event, it a Medical Examiner must be notified at 10d. Inside City Limits 10a State 10c. City, Town or Location 10b County 1X Yes 2 □ No Director Maryland | N/A Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21218 U.S.A. by Funeral 3034 Guilford Avenue 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ≥ 2 N No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Diet Writer Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Brown Davis Maggie Jane Fitzgerald Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Heelth a Important: If Itam 27 Is any Injury or other traces Joseph Fury Son 1225 Dulaney Valley Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4-29-04 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner • Hospital or Attending Physician: The law requires that the deeth certificate be executed 24 hours effor death. • Funeral Director: After this certificate has been signed by the attending abusing and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a consequence of melli tus Diabetes Division of Vital Records, P.O. Box 68760 the Due to (or as a consequence of): for use es Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ZNO 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 🗆 Yes 2-110 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No edical Certification: To within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral of 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Déath 28d. Describe how injury occurred 5 Pending investigation 1 Anatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Lertifying Phyaiclan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature, and title of certifier

State

Registrar

30. Name and address of person who

APR 2 8 2004

Vijoy R. Hegde

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

60539

N. Ewlow St., Suite 308, Baltimore, MD 21201

MO

821

ompleted cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

4-27-04

			1 - For State Registrar	State of Maryland		irtment of H			iene	nnı.	12201
	Physic	ian	1. Decedent's Name (First, Middle, Last)	EN		UNER		2. Date of Deat Month APAL	th Day	Year	3. Time of Death
2	/Medi Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or		th	4c. Count	y of Death $3AUTI$	
	Funeral Director		214-30 4214	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, 1934	9. Birthple Country	ce (State or Foreign y) MD
	death with the Maryland ms 23a or 28a-1 show I must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD BALT	10c. City,	Town or Lo	cation ESVILLE				100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28a	il Director	10e. Street and Number 4533 MARYKNOLL R	OAD		10f. Zip Code	21208	1	0g. Citizen of		y?
36		by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Ra	ce - Americar ck, White, et	
Maryland 21215-0036	filed within 72 hours after Hygiene. sther than "natural", or Its ont, the Madical Examine	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give i life. [ent's Usual Occupa kind of work done d OO NOT use retired, EMAKER	luring most of wo	rking	16b. Kind of B		stry
ylandz	should be filed nd Menta! Hygi i marked other umatic event,	To Be Co	17. Father's Name (First, Middle, Last) BENJAMIN		SLACH	TER	RITA	me (First, Middle, M	Maiden Sumar	ne)	LGOFF
	17 a 17 a 17 a 17 a 17 a 17 a 17 a 17 a		19a. Informant's Name/Relationship (Type I SRAEL BRAUNER /	HUSBAND	4533	MARYKNOL		ural Route Number, - PIKESVI			
galtimore,	Pages 1 and neut of Healint: If item 2 iry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	metery, crem	sition (Name of latory or other place NS CEMETE	· 1		OWING	City or Town	
Balt	permit. Pag Department Important: any injury o		21. Sign of Funeral Service Licens	mon	22.	Name and Addres	s of Facility	SOL LEVIN N ROAD -	ISON &	BROS.,	INC.
	Pnysician /Medical		23a. Part1. Enter the disease, or complie shock, or heart failure. List only the shock is a condition of the shock is a condition resulting in death)		Do not ente	er the mode of dying	g, such as cardia		est.	A tr	opproximate nterval Between Inset and Death
/60,	Examine be executed bhysician and physician and sthe burial-transit	dical Examiner	Sequentially list conditions, Tary, Learny to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	snea of):						
O. Box 68	ne death certifi the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 18 months? 1 ☐ Yes 2 Who 9 ☐ Unknown	c. If yes, outcome of pregnant 1 Live birth 2 Fetal c 4 Pregnant at time of dea	death 3 □	Ectopic pregnancy Other (specify)				te of delivery onth Da	ay Year
cords, P.	sign d be	þ	Part II. Other significant conditions cont	ributing to death but not result	ting in the un	derlying cause give	n in Part I.		acco use cont	ribute to the	cause of death?
Ľ	The law ate has b page 2 st	Completed						24a. Was ar autopsy perform 1 Yes 2	ned3/	prior to comp death?	y findings available letion of cause of
ion of Vital	Phy this	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mander of Death 1 Natural 5 Pending 2 Accident investigation	1	R/Outpatient 8b. Time of Injury	28c. Injury Work	r: 4 □ Nursing H	ath (Check only one name 5 Thesider 28d. Describe hor	nce 6 Oth		
DIVISION	To the Hospital or Attending I within 24 hobes after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 4 Homicide Getermined	28e. Place of Injury - At hom building, etc. (Specify)				28f. Location (Str. City or Town,	State)		
	in 24 hour in 24 hour	edicai	29a. Certifier (Check only one) (Check only one)	cian: To the best of my knowledge: On the basis of examination and manner stated	ledge, death on and/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	o, and due to the ca irred at the time, da	use(s) and ma te and place,	inner as state and due to th	ed. e cause(s)
)	with To 1	Z	29b. Signature and Merof certifier	l Koth	n m	29c. License	1491		Date signed	24.	2004
	0		30. Name and address of purson who com MUMFEL Re	pleted cause of eath (Item 2		COURT	RUAR	NAMPALLS	TOW M	ARYLA	WD 21133
	Sta Registr		31. Date filed (Month, Day, Year)	3. Registrar's Signatu	2	pouls				/	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or iteme 23a or 28e-f ehow

Division of Vital Records, P.O. Box 68760,

Phy /N Ex

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		1 = For Stata Registrar		State o	f Marylan		oartmen e <i>rtificat</i>				, ,	jiene ag. No.			
Physici /Medio		Decedent's Name (First)	, Middle, Li				BRA	FMAN	l		2. Date of Dear Month	-) Qui	3 Tirfue of	782
Examin		4a. Facility Name (If not in:	ral o	F Balt	imore		Ba	Itim		City			ty of Deeth	N/A	
uneral irector		5. Social Security Number 217-01-0991	L	Sex 1M M 2□F	7. Age (In yrs. I 84		y) If Under Months	Days	If Under Hours	Min.	8. Date of Birth	^Y 1919	9. Birth	place (State of	or Foreign
of show	tor	Usual Residence of Deceding 10a. State 10b. 0	County		10c. City	, Town or	Location TIMORE							10d. Inside C 1 X Yes	ity Limits 2 🗌 No
23a or 28e	al Director	10e. Street and Number 6210 PARK h	HEIGH	TS AVE.	#601		10f. Zip	Code	212	15	1	0g. Citizen o	What Cou	u.s.A	•
Important: if item 27 is marked other than "natural", or iteme 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	d by Funeral	11. Marital Status 1 Never Married 2(3 Widowed 4 Di	ivorced	Armed For 1 Yes If Yes, Gir Year or D	2 No		1 🗆 Yes	2 [X No	Specify:		city Yes or No- Rican, etc.)	Spec		etc. WHITE	
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m 27 ie ma ner treuma		19a. Informant's Name/Re BERNICE BRAS	FMAN ,		les s	621	.0 PARI	(HE)		AVE	#601 -	- BALT	MORE	, M.D.	2121
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any is		21. Signature of Funeral S 23a. Part1. Enter the dise	11/	Cuth	th		8900 i	REIST	TERST	OWN	ROAD - F	IKESV			
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certificate has been signed by the attending phy rector, page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 □ Yes 2 □ No 9 □ Unknown		1☐Live t	tcome of pregna birth 2 Fetal hant at time of de own	death 3	3 ⊟Ectopic pr 5 □ Other (sp						ate of deliv	-	Year
n signed by Ild be deta	b	Part II. Other significant of		contributing to d	eath but not resu	ulting in the	underlying c	ause give	en in Part I	l.	23e. Did tob	/		he cause of d	
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Funeret Dir etely filled in	Medical Cert	29a. Certifier 1 C	ertifying P ledical Exa	hysician: To the miner: On the b	be best of my knowasis of examinat	wledge, de	ath occurred investigation	at the tim in my op	ie, date ar pinion, dea	nd place, a	and due to the ca	ause(s) and n	nanner as s	stated. o the cause(s	i)
To the comple	Me	29b. Signature and title	ofither	,ms			290	License RES		0	2	9d. Date sign			
)		30. Name and address of JASON S		completed cau			e, Print) OS P T Ta	70 i	Balt	rom	e				
Sta Registi		31. Date filed (Month, Day APR 2 8 20		Seneral Server	Registrar's Signal	ture	rock	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** nne /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c! County of Deeth Examiner Sandtown Winchester uture Care TMORE ar I if Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** -0089 1 □ M 2 X F Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show the Medical Exercites trust be notified at 1 Yes 2 No Directo Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 Items 23a 21 Un Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, 11. Maritat Status Black, White, etc. 1 □ Never Married 2 □ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life._DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Department of Health and Menial Hy Important: If item 27 is marked oth any injury or other traumatic event once. Be Pages 1 and 2 should be nent of Health and Mental 2 19a. Informant's Na e/Relationship (Type, Print) (niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Barbar 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of al Home sep 21216 Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) reperovancian Physician 3425 /Medical **Examiner** no tro 2415 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown jo Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should be 4 Onknown 1 TYes 2 🗆 No 3 Probably Completed has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ဥ 1 Yes 2 No 1 Inpatient 4 ☐ Tursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 1. Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, within 24 hours a To the Funeral C Fo the Hospitel

> State Registrar

31. Date filed (Month, Day, Year) **APR 28**

Gam

30, Name and address of person who completed cause of death (Item, 23a), (Type, Print)

29b. Signature and title of certifier

amech

29a. Certifier

SabapaThi 3400 32. Registrar's Signature

Erdman

🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

3064

7more

29d, Date signed (Month, Day, Year)

		For State Registrar		State of	of Marylar	nd / Depa	artment of H	ealth and N Death		ene 2001	13381
5		1. Decedent's Nam	e (First, Middle,	Last)					2. Date of Death Month	Day Year	3. Time of Death
Physici /Medio		John		Vincent	:	Costa	1		April 26	2004	3:00a M
Examir		4a. Facility Name (f not institution,	give street and nu	mber)		4b. City, Town, or	Location of Death		4c. County of Death	1
		203 Reger			7 4 (1	Jane High days	Linthic	um If Under 24 Hrs.	0.0	Anne Aru	
Funeral Director		5. Social Security N 213-18-0		6. Sex 1 <u>⊠</u> M 2□ F	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birti	nplece (State or Foreign untry)
		Usual Residence of			01				July 10,	1922 Mar	yland
nylan show		10a. State	10b. County	. 11		ity, Town or Lo					10d. Inside City Limits
8a-1	Director	Maryland	L	Arunde1	L:	inthicu					1 ☐ Yes 2 ☐ No
with th	Die	10e. Street and Nu					10f. Zip Code			. Citizen of What Cor	untry?
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al', o	b	3 Widowed		If Yes, Gi Year or D	ve	'	1 ☐ Yes 2√2 No	Specify:		Specify:	White
72 hc	Completed	(Spec	15. Decedent'	s Education grade completed)		(Give	dent's Usual Occupa	luring most of work	ing 16	b. Kind of Business/I	ndustry
nethin han han	mp	Elementary/Seco	ndary (0-12)	College (1-4or 5+)	lite.	DO NOT use retired,)			
filed v Hygie ther t		12 17. Father's Name	(First, Middle, L	ast)		Mech	anic	18. Mother's Name	e (First, Middle, Ma	Garage	
d be sed o c eve	To Be	Salvato		_	sta			Modest	,	Costa	
shou nd M mar	-	19a. Informant's Na				19b. Mailir	ng Address (Street a			ity or Town, State, Zi	p Code)
and 2 alth a 27 is		Josephine	e Costa	(Wife)		203	Regency C	ircle, L	inthicum,	MD 21090	
of He of He fitam roth	1	20a. Method of Disp		3 □Removal from		Place of Dispo	sition (Name of natory or other place		Date 200	c. Location - City or T	own, State
Pag ment ant: I ury o		`4 □Donation	5 XOther (Sp	ecity) Entomb	ment Lo		ark Cemet			altimore,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Inportant: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examination and any injury or other traumatic event, I'm Medical Examination and any other traumatic event.		21. Signature of Fu	ineral Service L	icensee						Funeral H	
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		shock, or hea	rt failure. List o	nly one cause on e	aused the dea ach line.	th. Do not ent	er the mode of dying	, such as cardiac o	or respiratory arrest.		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause disease or condition resulting in death)		a	enal	tai	ure		<u>-</u>		month
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atten for u	Physician/M	23b. Was decedent in the past 12	months?	1 ☐ Live t	oirth 2 Feta	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
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aw re as bee	ompleted								24a. Was an	24b. Were auto	opsy findings available
	Com								autopsy performes 1 ☐ Yes 2	i? death? No 1 ☐ Yes	mpletion of cause of 2D No
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Attano death ctor: y the	ficat	2 Accident 3 Suicide	investiga 6 Could no determin	ot be	of Injury - At h	ome, farm, str	eet, factory, office	65 2 1140	28f. Location (Stree	t and Number or Run	al Route Number
after after Dire	Certification:	4 Homicide	deterrine	buildi	ng, etc. <i>(Specii</i>	(y)	, , , , , , , , , , , , , , , , , , , ,		City or Town, S		
To the Hospital or Attanding Pl within 24 hours after death. To the Funaral Director: After it completely filled in by the funera		29a. Certifier (Check only	Certifying	Physician: To the	best of my kno	wledge, death	occurred at the time	e, date and place,	and due to the caus	e(s) and manner as s	tated.
the Hin 24 the Fi	Medical	one)	1	and man	asis of examina ner stated.	ition and/or inv	estigation, in my op	inion, death occurr	ed at the time, date	and place, and due t	o the cause(s)
To To To To	2	29b. Signature and	title of certifier	20-	$\overline{}$		29c. License	number	29d.	Date signed (Month,	Day, Year)
. X\		1/1	n	1 De				556	1	prild	1,2004
3,		30. Name and address	1	completed caus	e of death (Iter	n 23a) (Type, I	Print)	1000	~ N-	d	12012
Sta	ite.	31. Date filed (Mont	7-7-1	32.	egistrar's Signa	ature	020,20	1 0),14	t) U/R.	monde	m ~100/
Registr		A	PR 2 8	2004	99.42 s	de do	ands)				
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

m			State of Maryland / Department of Health and M			_egible.	
			State of Maryland / Department of Health and M 1 - State Unpend Item #23a,21,28a I per me G831 5/4/04 tas Registrar Amend Item #18 per fh G831 5/4/04 tas ertificate of Death	F	Reg. No.	2004	13385
	Physici	ian	1. Decedent's Name (First, Middle, Last) JOCE LYN DENISE CRAWFORD	2. Date of Dea Month		2004	3. Time of Death
3	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	April		County of Death	5:46 PM
9			Maryland General Hospital Baltimore			N/A	
3	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F F F F F F F F F F F F F F F F F	8. Date of Birth Month_Day	195	9. Birthpla Count	ace (State or Foreign
1 - /	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	the Marylan 28a-f show	ctor	MD NA BALTIMORE				1 🗗 Yes 2 🗆 No
	with the	Funeral Director	10e. Street and Number 10f. Zip Code 21217		10g. Citiz	en of What Count	ry?
	ier death w itams 23a	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Forces)	cify Yes or No-	1-	USA 4. Race - America	
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or itams 23a or 28a-f show event, the Medical Examinational to modified at	by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes, Specify Cuban, Mexican, Puerto F 1 Yes, Give 1 Yes 2 No 1 Yes	Rican, etc.)		Black, White, e Specify: BLA	
21215-0036	72 hour		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kin	d of Business/Indu	
121	within 7	Completed	Elementary/Secondary (0-12) ,College (1-4or 5+) life. DO NOT use retired)	19	EDG	T FOOD	76
	Hygie other other	a	12/1H GRADE 4 YRS MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,	Maiden S		/3
Maryland		To B		BANKS	Eve	elyn Banks	
Mar	d 2 should th and Mer ?7 ia marke traumatic		19a. Informant's Name/Relationship (Type, Print) MALLORY CRAWFORD 19b. Mailing Address (Street and Number or Rural	BALTO	r, City or	Town, State, Zip C	20de)
ore,	iges 1 and 2 of Health: If itam 27 or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition Disposition (Name of Disposition (Name o		20c. Loc	ation - City or Tow	In, State
Baltimore,	permit. Pages Department of b Important: if its any injury or or once.		*4 Donation 5 Other (Specify) KING PARK U4 2	The second secon		dailstow	n, MD
Bal	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Lice Rep 22. Name and Address of Facility File State BALTO NATL PIK	INERAL E BAI	SER	VICE MD 2122	a
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			1	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) NARCOTIC (HEROIN) INIOXICATION AND COCAINE US	SE		,	Onset and Death
	Examiner		Due to (or as a consequence of):				
	ed	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
o,	be executed ician and burial-transit	Examiner	that initiated events c. C. Due to (or as a consequence of):				
68760,	ō × ō	dlcal	. d.				
Вох 6	eath certificat attanding phy I for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23	3d. Date of delivery	/
	ne death the atta hed for	Physiclan/Med	in the past 12 months? 1				yay Year
, P.O	s that the de ned by the e detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	bacco use	e contribute to the	cause of death?
ords	w requires been sign should be	ted b		1 □ Y€	es 2	Q o 3 ☐ Probab	bly 4 🗆 Unknown
of Vital Records,	The lay te has age 2	Completed		24a. Was a autops perform	ned?	prior to comp death?	sy findings available pletion of cause of
/ital	ician: T certificat rector, p	BeC	25. Was case referred to medical examiner? 26. Place of Death	(Check only on		1 SP Yes 2	□ No
of \		2	1 A Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Cther. 4 □ Nursing Hom	e 5 Reside	ence 6	Other (Specify)	
ion	Attanding I or death. actor: After by the funer	atlon	1 Natural 5 Pending For Month Day Year Injury Work?	NKNOWN	ove injury	00001180	
Division	f or Attanation after deatl	Certification:	3 ☐ Suicide 4 ☐ Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (St. City or Town		628 MOULL	OH STREET
_	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	ledical Co	29a. Certiflier (Check only only only only only only only only	LITMORE,	21150(5) 21	nd manner as stat	ed.
	thin 24	Medi	one) and manner stated. 29b. Signature and title of certifier 29c. License number			signed (Month, Da	
	F X F OS		O.C.M.E.			1 24, 200	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		100-		
	Sta	te	31. Date filed (Month, Jay, Year) 32. Registrar's Signature	ltimore	, Ma	ryland 2	1201
	Registr		31. Date filed (Month, Qay, Year) APR 2 8 2004				

ARL.	IE COOK		Amend Item 16b perafer 6890,64400/04/2040	idle nt of Health and Mi ficate of Death		iene 2004	13386
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Deat	th _	3. Time of Death
	Physici /Medio		Charlie Cook		APRIL	28, 2004	10:53 A M
1	Examir	er	3800 WEST BELVEDERE AVENUE APT. 1103	b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
	Funeral Director			Months Days Hours Min.	8. Date of Birth (Month, Day, 12/10/19		ace (State or Foreign ry) Carolina
	yland		10a. State 10b. County 10c. City, Town or Local	tion		10	d. Inside City Limits
	e Mar	ctor	Maryland Baltimore				1X Yes 2 □ No
	with th	Dire	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Count	ry?
	eath v	eral	3800 Belvedere Ave. Apt. 1103 11. Marital Status	21215	oify Voc or No	U.S.A.	n Indian
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23e or 28e-1 show or other traumatic event, It a Marical Examinate cust be natified at	by Funeral Director	Armed Forces? If Y 1 □ Never Married 2 □ XMarried 1 □ Yes 2 1 1 No	s Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, e	tc.
Maryland 21215-0036	nin 72 hou in "natura M. aleal E	Completed	(Specify only highest grade completed) (Give kin	t's Usual Occupation d of work done during most of workin NOT use retired)		16b. Kind of Business/Indi	ustry
21	ed witi	Com	6 Baker			Backing	
/land	2 should be filed within and Mental Hygiene. is marked other than aumatic event, It e M.	To Be	17. Father's Name (First, Middle, Last) Bennie Cook	18. Mother's Name Rosa Lee			
/an	2 sho and l is ma		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing A	Rosa Lee Address (Street and Number or Rural arriage Hill Circ	Route Number,	City or Town, State, Zip (Code) Stown
e,	1 and Health am 27 ther t					104 Marylar 20c. Location - City or Tov	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cremation	ory or other place) Cemetery 04/30/			
altir	permit. F Departme Importan any injur			ame and Address of Facility The			
ä				l Park Hgts. Ave.			
8760	/Medical bhysician and bhysician and the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to final disease or injury that initiated events resulting in death) Last Last Cause (Disease or injury that initiated events resulting in death) Last Last Cause (Disease or injury that initiated events resulting in death) Last Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	osclerotic Cardio	vascula	1	ntierval Batween Onset and Death
P.O. Box 687	ne death certif the attending thed for use as	Physician/Medic		topic pregnancy ther (specify)		23d. Date of deliven Month	/ Day Year
	w requires that the been signed by should be detact	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the under which the significant conditions contributing to death but not resulting in the under the conditions of the conditions are significant.	rlying cause given in Part I.		acco use contribute to the	C ,
Il Records,		Completed by			24a. Was an autopsy perform	prior to com	sy findings available of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
of	ding Phys h. After this funeral di	ation: To	27. Manner of Death 28a. Date of Injury (Month, Day Year) Although Science (Month, Day Year)	The state of the s		nce 6 AOther (Specify) w injury occurred	at scene
Division	ial or Attandi s after death. al Director: A ad in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, building, etc. (Specify)	factory, office 28	Bf. Location (Str. City or Town,	eet and Number or Rural I State)	Ro <i>ute Number</i> ,
	To the Hospital or Attani within 24 hours after deatl To tha Funaral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death oc 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, ar tigation, in my opinion, death occurred	d due to the cal d at the time, da	use(s) and manner as stat te and place, and due to to	ed. he cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier Theodore M. Keyners	29c. License number O.C.M.E	29	d. Date signed (Month, Da APRIL 26,	
	1			Street, Baltimore	e, Mary	land 21201	
4	Sta Registr	te ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature 4. APR 2.8 2004	conts)	-		

			1 - For State Registrar	State o	f Maryland		artment of F		d Mental Hy	giene Reg. No.	2nni.	13327
	Physici	an	1. Decedent's Name (First, Middle	, Last)					2. Date of De Month		Year	3. Time of Death
	/Medic	al	BESSIE	INEZ	CHERRY				April	20	2004	5:25 p ^M
	Examir	er	4a. Facility Name (If not institution		nber)		4b. City, Town, or BALTIMC		eath		County of Death BALTIMO	DT:
	Funeral		MANOR CARE-RIDO 5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 24 H		th		lace (State or Foreign
	Director		217-38-0799	1 □ M 2 XCX F	6	4 Yrs.	Months Days	Hours M	in. (Month, Da		Cour	RYLAND
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	eation					
	Aaryla F sho	ō		MIMODE	roc. Oxy,							0d. Inside City Limits 1 ☐ Yes 2XXNo
	28a-	Director	MARYLAND BAI 10e. Street and Number	TIMORE		BAL.	PIMORE 10f. Zip Code	-		10a, Citize	en of What Cour	150
	death with the Maryland ma 23a or 28a-f show Froust be rotified at		904 FOXRIDGE I	LN			2122	1			S.A.	,
	ama arma	Funerai	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S	. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14	4. Race - Americ Black, White,	
36	or It	by Fu	1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, Giv	2 XNo		_	Specify:	,,		Specify: BLA	
15-0036	be filed within 72 hours after death with the Marylar lat Hygiene. d other than "natural", or Itama 23a or 28a-f show evant, I'ra Medical Evantinar mant be notified at	q pa	3 Widowed 4 Divorced	Year or D	ates:	16a Dece	dent's Usual Occup	ation			d of Business/Inc	
Š	n "na	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)	40. F.()	(Give	kind of work done of DO NOT use retired	during most of v	vorking	100. Kill	J OI DUSINGSSAIR	dustry
2121	giene giene er tha	Com	10th grade	College (1	-401 5+)	НО	JSEWIFE			HOI	ME	
Maryland	be filed Ital Hygi d other evant, I	Be (17. Father's Name (First, Middle, i	Last)				18. Mother's N	lame (First, Middle,	Maiden S	iumame)	
<u>X</u>		70	LAWRENCE A JOH						IE ROBINS			
<u>a</u>	12 s h ar 7 is risu		19a. Informant's Name/Relationsh						Rural Route Numbe			·
<u>ق</u>	s 1 and f Health item 27 other ti		Tanya Cherry/Da 20a. Method of Disposition	iugiitei	20b. Pla	ce of Dispo	sition (Name of		, Balto.,		y Land 21 ation - City or To	
ē	0 0		1 🕅 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp		State	•	natory or other plac LLS MEMOR	1	-28-04			R, MARYLAND
Baltimore,	pernit. Page Department Important: It any injury o		21. Signature of Funeral Service I		11011				OMMUNITY			
n	e e m e o	-	Thales M.	Dout	el		206 W NOR			FUNEI	RAL HOME	S P.A.
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that conly one cause y e	aused the death. ach line.	Do not ent	er the mode of dyin	g, such as card	iac or respiratory ar	rest,		Approximate Interval Between
اسبغ	Physician		Immediate Cause (Final disease or condition resulting in death)	_a150	acterio	al	Sep8) S				Onset and Death
	/Medical Examiner		rosulting in douting	Due to	or as a conseque	noe of	0- 6	-1.	Mcer	ch	40 IV	el son h
		er	Sequentially list conditions if any, leading to immediate	b. Due to (or as a conseque	ence of):	ceno		or cer	3124	ge (V	4 1100
J	outed id ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c c								
/6U,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):						
8/6	icate be executed physician and s the burial-transit	dical		d								
o X O	the death certificate y the attending phys iched for use as the	/Me	IF FEMALE:	23c. If yes out	come of pregnance	ev.					10	
9	atten atten	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 ☐ Fetal d ant at time of dea	leath 3□	Ectopic pregnancy Other (specify)			23	d. Date of delive Month	ry Day Year
o.	t the c by the achec	hysi	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unkno	own		() () ()			İ		
Š,	taw requires that the de as been signed by the a 2 should be detached	by P	Part II. Other significant condition	ns contributing to de	eath but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
cords	equire sen si ould l	ted		yper	jens	201	3		1 🗆 Y	es 2	No 3 ☐ Proba	ably 4 □Unknown
ပ္	2 2 2	Completed		U					24a. Was a	sy	prior to con	osy findings available appletion of cause of
E	Tate	Con							1X Yes	med? 2□No	death? 1 Yes	2 X No
VII	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		eath Check on or			
ō	Attending Physician: r death. ector: Afler this certifice by the funeral director.	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date (of Injury 2	R/Outpatien 8b. Time of	28c. Injury	at at	Home 5 Resid)
0	nding ath. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investig		h, Day Year)	Injury	Work	(? Yes 2 □No				
DIVISION	Atte	Certification:	3 Suicide 6 Could n 4 Homicide determi	288. Place	of Injury - At homing, etc. (Specify)	ie, farm, stri	eet, factory, office		28f. Location (S City or Tow	itreet and I	Number or Rural	Route Number,
5	ital or irs afte ral Di	Cer							0.0, 0.70	,, Olato,		
	To the Hospital or Attendi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	edical	(Check only 2 Medical b	Physician: To the xaminer: On the ba	isis of examinatio	edge, death in and/or inv	occurred at the tim	e, date and pla pinion, death oc	ce, and due to the courred at the time, o	ause(s) ar	nd manner as sta lace, and due to	ited. the cause(s)
	o the ithin 2 o tha	Med	29b. Signature and tipe of certifier	and manr			29c. License	number		29d. Date s	signed (Month, L	Dav. Year)
)	F 3 F 8		> Kran	· w	9		Do	253	91	4	- 26	- 2004
	1/		30. Name and address of person v	y/o completed caus	e of death (Item 2	23a) (Typey	Print	0	1 1 1	1	1.	MD 21239
	Sta	to	31. Date filed (Month, Day, Year)		egistrar's Signatu		Kave	n 131	val, 19	alt	D'UNE T	2125
	Registr		APR 2 8 20	1 1.	arras	La	1					

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla				ealth ar Death	nd Me		iene	004	13388
			Decedent's Name (First, Middle, Last	st)					2	2. Date of Deat	h	Vana	3. Time of Death
	Physici /Medic		George S. Chi	ttum						Month 04	23	2004	8:30 A ^M
8.	Examin		4a. Fecility Name (If not institution, give	street and number)				Location of I				ounty of Death	
			Mariner Healt					Burni			Anı	ne Aru	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	Months	Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day,	Year)	9. Birthi	olece (State or Foreign ntry)
	Director		229-05-8043 Usual Residence of Decedent	A -	87 Yrs.					08/29/	1910	6 VA	
	/land		10a. State 10b. County	10c.	City, Town or Lo	cation							10d. Inside City Limits
	Man	tor	MD Anne Ar	undel	Glen Bu	rni	P						1 ☐ Yes 2 ☐XNo
	or 28,	Funeral Director	10e. Street and Number	MILLON TO THE STATE OF THE STAT			p Code		·	10	og. Citizer	n of What Cou	ntry?
	th wil	ai D	337 5th Avenue			2	1227					USA	
	eeb r	Iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Dece i Yes, spe	edent of Hi	spanic Origir n, Mexican, F	n? (Speci Puerto Ri	ify Yes or No- can, etc.)	14.	Race - American Black, White,	
36	hours after deeth with the Maryland turel', or Itema 23a or 28a-f ehow al Eraminar mest be multied at	by Fi	1 ☐ Never Mamed 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 No If Yes, Give	1	Yes	2 X No	Specify:			Sp	pecify: Wh	ite
8	d within 72 hours after deeth with the Marylan jiene. tran "naturel", or Items 23a or 28a-f ehow tra Medical Enarthme trinal be indiffied at	ed b	15. Decedent's Ed	Year or Dates:	16a. Deced	lent's Use	al Occuna	ation		1 .	I6b Kind	of Business/in	
15	within 72 ene. than "na	Completed	(Specify only highest gra		(Give	kind of w	ork done d use retired,	furing most o	f working	7			,
212	d with	ШО	Elementary/Secondary (0-12)	College (1-401 5+)	Home	Re	pair	S			Cc	onstru	ction
פ	e filed al Hygi other	Bec	17. Father's Name (First, Middle, Last)						Name (First, Middle, M	fa <i>iden S</i> u	mame)	
<u>a</u>	should be filed nd Mental Hygi marked other umatic event, I	Tof	James Chittum							th Har		_	
Maryland 21215-0036	2 6 5 5		19a. Informant's Name/Relationship			-				Route Number,			Code)
	and and m 27		Patricia Fitzg		ter) 1934								Ctata
altimore,	Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	memoval from State	cemetery, crem			, ,	April		. 0 . [tion - City or To BOX 296	6
Ē	permit. Pages Department of Importent: If I eny injury or o		'4 □Donation '5 □Other (Specifi		etro Cre				200				D 21229
Bai	Department of the popular in the pop		21. Signature of Funeral Service Lice	Sep /				s of Facility	Sta	allings	Fune	eral Ho	me, P.A.
			23a Part 1. Poter the disease, or com	plications hat caused the d						Pasade respiratory arre		אט צווצ	Approximate
			23a. Part1, Enter the disease, or comshock, or heart failure. Sist only	one cause on each line.									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a cons		movo	melo	n N	tu	dent			days
Ц	Examiner			Due to tot as a cons	equence or).								
	1	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):								
	outed od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.									
Ó	be executed sician and burial-transit		resulting in death) Last	Due to (or as a cons	equence of):								
3760	16 × 16	licai		d									
89 ×	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE:	00- 14								1	
Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of prediction 1 Live birth 2 F	etel death 3	Ectopic p	regnancy				23d	. Date of delive Month	ery Day Year
o O	0 0 0	ysic	1 Yes 2 No	9□ Unknown	roeath 5	Other (S	pecity)						
<u> </u>	The law requires that the te has been signed by the age 2 should be detached.		Part II. Other significant conditions of	ontributing to death but not	resulting in the un	derlying	cause give	n in Part I.		23e. Did tob	acco use	contribute to the	ne cause of death?
OS	uires sign ld be	d by	Diobetes Mel	liho						1 ☐ Ye	s 2 🗆 N	lo 3 Prot	ably 4 Unknown
o o	w requires	lete	Aemintia							24a. Was an	2	4b. Were auto	psy findings available mpletion of cause of
H	The lav	Completed								autopsy	ed?	prior to co death? 1 \(\sum \text{Yes}	
Vital Records,	- G - L	BeC	25. Was case referred to medical					26. Place of	f Death (1 Yes 2		1 163	2 140
5	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3 D	OA Othe	4 Nursi	ing Home	5 🗆 Resider	nce 6 🗆	Other (Specif	y)
o c	ding Ph. After thi funeral		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury		28c. Injury Work	at ?		d. Describe hor			
0	andir sath. or: Af he fu	atlc	2 Accident investigation			М	1 🗆 Y	′es 2□No)				
Division	ter de lirect	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	et, factor	y, office		28	 Location (Str. City or Town, 		lum <i>ber or Rur</i> a	I Route Number,
	urs at oral D												
	To the Hospitel or Attending Physicien: whithis 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 SaCertifying Ph (Check only 2 Medical Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	ination and/or inv	estigation	at the tim n, in my op	e, date and p inion, death	occurred	at the time, da	use(s) and te and pla	d manner as s ice, and due to	tated. the cause(s)
	ithin i	Mec	29b. Signature and title of certifier	grid marries stated.			c. License					igned (Month,	
i	⊢ s ⊢ ŏ		1 Molloney	MD-			D-4	.0521		1	April	23,20	4
	N		30. Name and address of person who	completed cause of death (I	tem 23a) (Type. I	Print) 7	370	WILL	ens	Arem	e 5	Lite on	"
	4 (DL OCHANE			B	offin	ure 1	MD	Arem 2122	7		_
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature			7 (
	Registr	ar	APR 2.8	2004	10	1							

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For Stete Registrar	State of M	arylar	•	artmen rtificate			ind M		Reg. (ne No. 20	04	133	80
Physic		1. Decedent's Name (First, Middle, Las Robert Lee Chenow								2. Date of C Month April	Death 25	2004	Year	3. Time of D	
/Medi Examir		4a. Facility Nam <i>e (If not institution, give</i> 1254 Fairway Driv)	***************************************			Location of	Death	1		4c. County o		7.00	-
Funeral Director			7. Ag	ge (In yrs. 80	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of E (Month, I lay 1	Birth Day, Yea 7, 19	923	9. Birthp Cour Viar	place (State or F ntry) yland	Foreign
e Maryland ta-f show lifted	ctor	Usual Residence of Decedent 10a. State 10b. County L'D Carrol	1		ty, Town or Lo Strainst			·					1	0d. Inside City	
h with th	al Dire	10e. Street and Number 1264 Fairway Dri	ve			10f. Zip	code 21157	7			10g.	Citizen of W		ntry?	
urs after deat il', or Items ?	by Funeral Director	11. Marital Status 1 ☐ Never Married 2☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 冠Yes 2☐ If Yes, Give Year or Dates:	?	+3-	Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican, Specity:	in? (Spe Puerto I	cify Yes or f Rican, etc.)	No-		, White,	ean Indian, etc. Mite	
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examinat must be nutified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12		5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us NCINIST	al Occupa rk done d se retired,	ution uring most	of workir	ng	16b.	Kind of Bus		dustry ernment	
d a b	To Be C	17. Father's Name (First, Middle, Last) Raymond Chenowet	'n							(First, Midd Wheat		len Sumame	9)		
s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	i	19a. Informant's Name/Relationship (7 Bonnie Lankford/D		20h (835 (hante	er Dr	ive,	West	Route Num minst ate	er,	MD 21	157		
Page nent o ent: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Can	Place of Disponentery, creed Troll (Cremat	ion,	Inc4/	29/2	2004	Han	Location - 0	d, Ø	D	
permit. Departr Importe any inj		21. Signature of Funeral Service Licen	mbru	\	(028 8	ykes	ville	Roa	Zumb ad, El	ders	F.H.;	MD	. Co. 21734	
Pnysician /Medical		23a. Pavl 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	nd	Stagi	er the mod	e of dying	, such as o	cardiac or	r respiratory	arrest,			Approximate Interval Betwe Onset and De	en ath
te be executed ysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as d.												
death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	uldeath 3[Ectopic pr						23d. Date Mon		nry Day Yea	ar
The law requires that the de tte has been signed by the a page 2 should be detached	ğ	Part II. Other significent conditions co	ontributing to death t	but not res	sulting in the u	nderlying c	ause give	n in Part I.						ne cause of dea	
2 2 2	Completed										opsy formed	? de	ere autorior to consath?	psy findings avanting avantings avan	ailable se of
sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ient 2] ER/Outpatier	nt 3 DC	Othe	APP	of Death	(Check only		6 □Othe	/Specifi	4)	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury	28b. Time o Injury		8c. Injury Work	at	2	8d. Describ				/	
e Hospital or Atland 24 hours after death B Funerel Director: etely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, e	tc. (Speci	fy)					City or T	own, Sta	ate)		l Route Numbe	or,
To the Hospital within 24 hours of To the Funeral completely filled	Medical	29a. Certifier Certifying Ph (Check only 2 Medicel Exemone)	ysician: To the best liner: On the basis of and manner si	of examina	owledge, deat ation and/or in	n occurred vectigation	at the tim in my op	e, date and inion, death	l place, a h occurre	nd due to the d at the time	e cause e, date a	(s) and man and place, a	ner as st nd due to	ated. the cause(s)	
To the To the	M	29b. Signature and title of certifier	forsbe	4			License		,			Date signed			
41		30. Name and oddress of person who of	completed cause of	death (Iter	m 23a) (Type,	Print)	Wa	4#1	114	Eld	15	ensq.	am	2178	14
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2	32. Regist 8 2004	rar Sign	ature	dos	all s					7			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	Maryla		artment of F rtificate of	Health and N Death		giene 2 (004	13390
	Physic		1. Decedent's Name (First, Midd	lle, Last)					2. Date of Dea	ith		3. Time of Death
	Physic /Medi		Minnie Bell						Month 4/25	/ 0 4	Year	1030 AM
	Exami	ner	4a. Facility Name (If not institution				4b. City, Town, o	or Location of Death		4c. County	of Death	
-			Joseph Ritch 5. Social Security Number			food blidby 1 - 1	Balti If Under 1 Year		T		I/A	
F	Funeral Director		219-22-4494	1 M 2 F	Age (in yrs	6 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 9 / 0 7 /	1 9 2 7	Cour	place (State or Foreign htry) timore MI
0	land		Usual Residence of Decedent 10a. State 10b. County	/	10c. C	ity, Town or Lo	cation					0d. Inside City Limits
3	72 hours after death with the Maryland neturel', or Items 23e or 28e-f ehow dical Examination in Allies and	ğ	MD N/A		B	altimo	ro				ľ	1 ☐ Yes 2 ☐ No
0	1 the	Director	10e. Street and Number		D,	arcinc	10f. Zip Code			l0g. Citizen of	What Cour	42
~	th with 23a or	O E	2009 Bryant	Avenue			2121	7		USA		,.
3	ours after death v el', or Items 23e Exdir for must	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U	J.S. 13. \		lispanic Origin? (Sp. an, Mexican, Puerto	ecify Yes or No-		e - Americ	
9	or Its		1 ☐ Never Married 2 ☐ Mai	rried 1 Yes 2	JNo X	1		Specify:	Hican, etc.)		ck, White,	etc.
o √ 5-003	72 hours "neturel", idical Exa	d by	3 ☐ Widowed 4 ☐ Divorced		<u>. </u>		I□Yes 2□No			Specify	Bl	ack
0 7	- 178	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of B	usiness/Ind	dustry
5-	within jiene.	E C	Elementary/Secondary (0-12) 12 years	College (1-4o	r 5+)			llector		Insur	ance	
	be filed ital Hygie d other event,	a)	17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle, i			
-2 land		To B	Fred Crocket	t				arrie R				
aryl			19a. Informant's Name/Relations			19b. Mailin		and Number or Rura			State, Zip	Code)
Σ	1 and 2 Health a tem 27 ie		Joyce Fitcha	tt/ niece		217	Rock Cr	eek Rd,	Wasin	ton.	DC 2	0011
נראל זכ altimore,	es 1 and of Heatti fitem 27 r other 1		20a. Method of Disposition	2 🗆 🖰 🖰		Place of Dispo:	sition (Name of natory or other place			20c. Location -		
₹ ï	Pag ment ant: I		1 ₩ Burial 2 ☐ Cremation 1 ♣ Donation 5 ☐ Other (5	Specify)	θ	rbutus	,	, I	0/04 E	Balto,	MD	
Gillanore,	permit. Pages Department of Himportant: If ite eny injury or of once.		21. Signature of Furferal Service	Licentee	\bigcirc		Name and Addres		Horney AB	OO T41	MD	,21207 y Heights
1	1		23a. Part1. Enter the disease, o	r complications that cause	ed th ea	th. Do not ente	or the mode of dyin	ig, such as cardiac of	or respiratory arre	est.	Del C	Approximate
	Physician		Immediate Cause (Final	only one cause on each	ilne.	+ 1						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a	s a consec		ung can	rcei		· · · · · · · · · · · · · · · · · · ·		Zyrs
	Examiner		Coguantia II. link con dikiona	h								,
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Unusnying	Due to (or a	s a consec	quence of):						
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
60,	be ex ician burial	E	Total Market Control	Due to (or a	s a consec	quence of):						
رم) 18760,	icate be physicia s the bur	dical		d	_						-	
×	eath certific attending p	Ψ	IF FEMALE:	23c. If yes, outcom	e of pregna	ancv						
B	death of atten	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fete	oldeath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver oth	Day Year
30	the d	Jys	9 Unknown	9□ Unknown			Outer (specify)					
2.	equires that the de sen signed by the a rould be detached t	y P	Part II. Other significant condition	ons contributing to death	but not res	sulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to the	a cause of death?
3 5	w require been sig should b								1 <u>□</u> Ye	s 2 🗆 No	3 Proba	ably 4 🗆 Unknown
- PC	2 0 %	Completed							24a. Was ar	24b. V	Vere autop	sy findings available
) E	The law ate has page 2 :	mo							autopsy	100% d	leath?	sy findings available ipletion of cause of
Vital	sicien: Th certificate rector, pag	0	25. Was case referred to medica	1				26. Place of Death	(Check only one		☐ Yes 2	2 (2 N o
\$ \(\psi' \)	nysic nis ce direc	To B	examiner? 1 □ Yes 2 ②No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatient	3□ DOA Othe			/	er (Specify)	Hospice
	ng Pł fter tł meral		27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	28c. Injury Work	at 2	28d. Describe ho			Tiespie
Sio	Attending r death. sctor: Afte	catio	2 Accident investi	gation		,,		Yes 2 □No				
$N_1 N_N$ Division	r Att	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be lined 28e. Place of Ir building, e	njury - At ho	ome, farm, stre	et, factory, office	2	28f. Location (Str. City or Town,	eet and Numbe State)	or Or Rural	Route Number,
50	oital o		/									
1	To the Hoppital or Attending Physicien: within 24 tobys after death. To the Fulzefel Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 TC Certifyir (Check only one) 2 Medical	ig Physician: To the besi Examiner: On the basis of and manner s	oi examina	wledge, death tion and/or invi	occurred at the time estigation, in my op	e, date and place, a pinion, death occurre	ind due to the ca od at the time, da	use(s) and mar te and place, a	nner as sta nd due to t	ted. the cause(s)
	To the To the comp	ž	29b. Signature and title of certifie	r			29c. License		29	d. Date signed	(Month, D	ay, Year)
	. [1 2/80	ND			D2	24170		April 2	26,20	204
-	4		30. Name and address of person	who completed cause of	death (Item	23a) (Type, P	rint) A) E.+	24170 aw St.	Bally -		ID ~	201
	Sta	te.	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa		10,04	aw 31.	ratio	nore p	VU	201
	Registr		APR 2 8 20			B	backer					
			APR S O SI	104		1	10000					

			1- For Amend Item 2 State of Marylan, 06/22	គ្ ក្រុក្សក្ស of Health and N ertificate of Death		piene 2004 13391
			Decedent's Name (First, Middle, Last)		2. Date of Dea	th04/27/2004 3. Time of Death
	Physici /Medio		John L. Dickerson		Month March 2	27, 2004 Year 12:00 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Continuum Care	Sykesville		Carrol1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth	
	Director		719-01-1602 1⊠M 2□F 87 Yrs.	Months Days Hours Min.	Mar. 10), 1916 Virginia
	P .		Usual Residence of Decedent			
	aryla shov	_	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Ba-f	cto	Maryland Carroll Sykesvil	le		1 ☐ Yes 2 ☑ No
	ib 4	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Country?
	ath v	ā	7309 2nd Ave	21784		nited States
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or liems 23a or 28a-f show aumatic event, the Madical Examinar must be multified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Splf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Ş	bot in the	ed		dent's Usual Occupation		16h Kind of Business/Industry
21215-0036	in 72	Completed	(Specify only highest grade completed) (Giv	kind of work done during most of work DO NOT use retired)	ring	16b. Kind of Business/Industry
7	the end	E	Elementary/Secondary (0-12) College (1-4or 5+)	duler		CSX Railroad
0	other ont,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	
Maryland	d be ental ked o	ToB	John Paul Dickerson	Helen Mc		
2	should and Men marke umatic	-		ng Address (Street and Number or Run		City or Town State Zip Code)
Ž	and 2 lealth a m 27 is her tra			Duvall Rd. Woodbi		
ė	- I O =					20c. Location - City or Town, State
Ê	Pages net of int: If it		I I Dental 2 to Orientation 3 Intelligent from State	ty Cremation 4/28/	2007	Sulvaged 11a MD
Baltimore,	permit. Pages Department of Important: If it any injury or o		21, Signature of Funeral Service Licenses	Name and Address of Facility		ykesville, MD
ñ	Per Per Per Per Per Per Per Per Per Per		Bt	ırrier-Queen Funer 212 W. Old Liberty	al Direc	tors, P.A.
	rnysician /Medical Examiner		238. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	er the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of t	or respiratory arre	est, Approximate Interval Between
8760,	cale be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of):			
O. Box 6	ine law requires that the beath centrications to the attending to age 2 should be detached for use as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ras, r	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to the cause of deaty? s 2 □ No 3 □ Probably 4 ⊡Unknown
Hecord	as been si	ompieted	SIP Paremater del	hellion.	24a. Was an autopsy	
	sicient. The law scertificate has t lirector, page 2 s	Con	Corr C.O intake.		perform	ed? death? ☑No 1 ☐ Yes 2 ☐ No
VITA	entific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
5	r this certific	မှ	1 ☐ Yes 2 ☐ ₩6 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing Hor	me 5 Resider	nce 6 ☐Other (Specify)
	ofter (no ::	27. Manner of Death 28a. Date of Injury 1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury	28c. injury at Work?	28d. Describe how	w injury occurred
200	or: A	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
DIVISION	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	4 Homicide determined 286. Place of Injury - At home, farm, sti		City or Town,	
3	in 24 hou	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the car ed at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
F	To T	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
			Stirtung; MD	130119		
				730//1		4/11/04
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, LHAHIDA LLDIBE (L)		Road	Sylvenille MD

			1 - For State of Maryland / Deparation Registrar State of Maryland / Deparation Cert	artment of Health and Mental tificate of Death			
	Physic /Medi		minni D. DECKMAN	2, Date Mont Apri	of Death th Day Year 3. Time of Death		
	Exami	ner	Upper Chesapeake Medical Center	4b. City, Town, or Location of Death Bel Air	4c. County of Death Harford		
	Funeral Director		5. Social Security Number 215-42-5242 6. Sex 1 M 2 \square F 6. Sex \square F 6. Sex \square Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. 12/12	of Birth th, Day, Year) 2/1941 9. Birthplace (State or Foreign Country) Maryland		
	a-f ehow	ctor	10a. State 10b. County 10c. City, Town or Loc		10d. Inside City Limits 1 ☐ Yes ※ No		
21215-0036	th with the 23s or 28 Ist be no	al Dire	10e. Street and Number 1139 Poplar Grove Road	10f. Zip Code 21154	10g. Citizen of What Country? USA		
	pormit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Di perinnent of Heelth end Mental Ptyglene. In portant: if item 27 is marked other than "natural", or itema 23a or 28a-f ehow ery njury or other traumatic event, if a Modical Examinar must be notified at each one.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Vas Decedent of Hispanic Origin? (Specify Yes Yes, specify Cuban, Mexican, Puerto Rican, etc	or No- 14. Race - American Indian, Black, White, etc. Specify: White		
	filed within 72 h Hygiene. Ither than "natu ent, Ine Mudical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Sho	ent's Usual Occupation kind of work done during most of working O NOT use retired) Demaker	16b. Kind of Business/Industry Manufacturing		
Maryland	should be fill nd Mental Hy i marked oth umatic event	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Ma Gladys Marie			
	end 2 sh eelth end m 27 is m		Lioyd O. Deckman/Brotner 3428A	Address (Street and Number or Rural Route No. Dublin Road, Darlingt	lumber, City or Town, State, Zip Code) con , MD 21034		
	mit. Peges 1 pertment of H portant: if ite y njury or ott		'4 Donation 5 Other (Specify) Dublin 5	ition (Name of atory or other place) Cuthern Cemetery 4/29/2004 Name and Address of Facility	20c. Location - City or Town, State Darlington, MD		
ň	90 T 9 9			arkins Funeral Home, Inc., 60	00 Main St., Delta, PA 17314		
8/60,	death certificate be executed Medical Ex Medical Medi	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Under in. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Angenction	Onset and Death We will		
O. Box 6	the death certific y the attending pl ached for use as t	Physician/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year		
ords, P	The law requires that the de tte has been signed by the a page 2 should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the und		Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
		Completed	O besity	a p	Was an autopsy autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
=	ਵੇ ≝ □	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Montarial 5 Pending (Month, Day Year) 2 Accident investigation		nfy one) Residence 6 □Other (Specify) ribe how injury occurred		
	To the Hospitiel or Attending P within 24 hours elter death. To the Funeral Director: After the completely filled in by the funeral.	Certific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify) 29a. Certifier 1 Certifying Physicien: To the best of my knowledge death of	City or	on (Street and Number or Rural Route Number, Town, State)		
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1	Z × Z		P a la	29c. License number	29d. Date signed (Month, Day, Year)		
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri CRAIC SHAUGIJ NESS YM BELAIR HLT	int) H CATR 104 PLONTR	Cepne 24, 2004 EE Rd, BEL AIR 2/014		
į	Stat Registra	e	31. Date filed (Month, Day, Year) APR 2 8 2004	R	- 1V, 1000 111K 8/0/7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** April 26, 2004 3:45 A Eleanor C. Dombroski /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ F 84 Dec. 1919 213-03-1543 26, Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10h County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Baltimore Director Baltimore Maruland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 21236 4102 Taylor Ave., Unit 129 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 XWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6th Grade Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Walter J. Tillie. Dombroski Lamka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 10236 Windsor Way, Powell, Ohio 43065 (niece) Mrs. Denise Burgers Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/29/2004 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Because Kd., Buttimone,
1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 9705 Belair Rd., Saltimore, MD 21236 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelodysplastic

Due to (or a /a consequence f): Syndrome Physician 6 Vrs /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the at d be detached for P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 6 Other (Specify) HOSPICE 2 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death To the Funeral Director: 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 20 1 Certifying Physician: To the best of thy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E. Tso MD Richey Hospice 838 N. Entaw St. Britimore MD 21201 Richey Hospice 32. Registrar's Signature 31. Date filed (Month, Day, Year) State^{*} APR 28 Registrar

DHMH 17 Rev 1/2001

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Security Security	any in	21. Signatura of Funeral Servica License	P	22. Name	and Address of Facility S	chimunek F	uneral	Homes	
Immediate Cause (Final disease or condition resulting in death) Sequentially, its conditions is any, leading to mmediate cause, Enter Underlying in death) Associated Cause, Enter Underlying in death) Last	100	22 Plut Enter the disease or compli	nations that assumed the death						
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North Sall Wo RES 000 4-23-04	ne runers pletely fills edical ((Check only 2 Medical Examin	ier: On the basis of examination	rledge, death occurre on and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and man e and place, ar	ner as stated. nd due to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To T	29b. Signature and title of certifier		2	9c. License number		_		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Dr. Lister Ball, 9000 For Min Same Drive Balt more Mn 2123	1	1 Kursten 16	all mas		RES 000	4	1-23	-04	
Dr. Hirsten Ball, 4000 Franklin Same Drive Bultimore, MD 2123	1	30. Name and address of person who co-	mpleted cause of death (Item :	23a) (Type, Print)					
		Dr. Kirsten Dr	111, 9000 Fr	aphlin S	grate Drive	Balt m	050	MO 21237	

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Drumfoole, John

		_ For		aryland / Dep	artment of Health and I	Mental Hygi	ene	10005			
		1 - State Registrar		Ce	rtificate of Death		g. No. 2004	13395			
Physic		1. Decedent's Name (First, Middle, L Virtus E.	^{ast)} Evans			2. Date of Death Month April	21 2004	3. Time of Death 3:00 P M			
/Medi Exami		4e. Fecility Name (If not institution, g	ive street and number)		4b. City, Town, or Location of Death	1	4c. County of Death				
		Washington Adve			Takoma Park		Montgome				
Funeral Director		5. Social Security Number 6. 255-14-0462	Sex 7. Ag 1AM 2☐F	e (In yrs. last birthday, 83 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, July 4,	1920 9. Birth	place (State or Foreign intry) eorgia			
De s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits			
aryla	P.	D.C.		Washing				tX Yes 2 No			
the N	Funeral Director	10e. Street and Number		1100112118	10f. Zip Code	10	g. Citizen of What Co	untry?			
with Sa or	0	1744 Allison S	troot N F		20017		USA	A			
death ms 2:	era	1/44 ATTISON 3	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Amer Black, White				
(I Z 1 Z 13-UU30 filed within 72 hours after death with the Maryland Hygiene Hybrer than "natural", or Items 23a or 28a-f show ent, the Medical Examinan trust be notilised at	y Fur	1 ☐ Never Married 2 ▼ Married	If Yes, Give		1 ☐ Yes 2K No Specify:	o mean, etc.)	11.1	lack			
hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:		edent's Usual Occupation		16b. Kind of Business/l	ndustry			
n 72	lete	15. Decedent's (Specify only highest of	rade completed)	(Giv	e kind of work done during most of wor DO NOT use retired)	rking					
iene.	Completed	Elementary/Secondary (0-12)	College (1-4or	M.	ail Room Clerk		U.S. Gov	ernment			
ytand y buld be filed Mental Hyg arked other atic event.	Be C	17. Father's Name (First, Middle, La John W. Evans	st)			me (First, Middle, A Chapman	Maiden Surname)				
BAITIMOTE, INIGITY ISING ALL 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23s or 28e-1 show sny injury or other traumatic event, the Medical Examiner must be notified at some.	To	19a. Informant's Name/Relationship Indiana S. Evan	(Type, Print)		ing Address (Street and Number or Re 4 Allison St., NE,	ural Route Number, Washingt	City or Town, State, Z on, DC 200	ip Code) 17			
ore, not health		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place of Disp	amatory or other place)		20c. Location - City or Suitland,				
SAITIMOTE Sermit. Pages 1 Department of He mportant: If iter iny injury or oth once.		*4 □Donation 5 □ Other (Spe 21. Signal • Funeral Service Lice	city)	wasningt	22. Name and Address of Facility	Latney's	Funeral Ho	me			
		Colph !	Melin		3831 Georgia Ave.						
Physician /Medical		23a/ Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
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68 A	d	`	d								
death cert e attending for use	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetel death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year			
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The law page 2 st	Completed					24a. Was a autops perform	y prior to o	topsy findings available completion of cause of 22No			
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of Vita Physician: this certific al director,	To E	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 Inpat	ient 2 ER/Outpati			ence 6 Other (Spe	cify)			
On O ding Ph th. : Alter th	itlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of In (Month, D	ay Year) 28b. Time Injury		28d. Describe ho	ow injury occurred				
Division of Vital Records, or Attanding Physician: The law requires taffer dath. Director: Atter this certificate has been signe in by the tuneral director, page 2 should be	Certification:	3 Suicide 6 Could no 4 Homicide determin	280. Flace of II	njury - At home, farm, setc. (Specify)	street, factory, office	eet and Number or Rural Route Number, State)					
Division of Vital Volta with a Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: Alter this certifical completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes	t of my knowledge, de of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)			
o the ithin 2 or the vmple	Mec	29b. Signature and title of certifier			29c. License number	2	9d. Date signed (Mont	h, Day, Year)			
£ ₹ £ 8		> Mla-	.MD		D 18895	P	Hpil23,	2004			
6		30. Name and address of person w	no completed cause of	death (Item 23a) (Typ		OMAPAR	K, MD2	-0912			
	itate strar	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	the Amelia						
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DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Ma	aryland / Dep <i>Ce</i>	artment of F	lealth ar <i>Death</i>	nd Men	tal Hygie	ene 200	4 13391	5
			Decedent's Name (First, Middle, Last)						ate of Death		3. Time of Death	_
	Physici		Bernard Louis Endl	ich					ril 23	Day Yeer 2004		
>	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of			4c. County of De		_
	EXAMINI	eı	Carroll Lutheran Vi			Westmins	ter			Carrol1		
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday	If Under 1 Year		4 Hrs. 8. D	ate of Birth Month, Dey,	9. B	inthplace (State or Foreign Country)	
	Director		214-30-5440	M 2□F	69 Yrs.	Months Days	Hours	Ap:	ril 2,	1935 Ma	ryland	
	P .		Usual Residence of Decedent		10c. City, Town or L	castina					10d. Inside City Limits	_
	aryla shov	_	10a. State 10b. County								1 ☐ Yes 2 🖾 No	
	8a-f	Director	Maryland Carroll		Sykesvill				10.	. Citizen of What (
	with ti	ă	10e. Street and Number			10f. Zip Code					•	
	s 23	erai	3800 Robin Hood Way	12. Was Decedent 6	ever in IIS 13	21784 Was Decedent of H	lispanic Origin	in? (Specify		nited Sta	tes nerican Indian,	_
	lter de	Funerai	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cubi	an, Mexican,	Puerto Rica	n, etc.)	Black, Wh		
336	urs af	by I	3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	1963	1 ☐ Yes 2 ☑ No	Specify:			Specify:	White	
21215-0036	4 within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show Ite Madical Exemple or must be notified at	ted	15. Decedent's Educ		16a, Dece	edent's Usual Occup	pation	of working	16	Sb. Kind of Busines	s/Industry	_
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ы		Be	17. Father's Name (First, Middle, Last)					,		iden Sumame)		
yla		ို	Louis B. Endlich					Robin				_
Maryland	2 2 2 2 D		19a. Informant's Name/Relationship (Type Elizabeth Endlich			ing Address (Street Robin Ho				-		
	1 and 1 and		20a, Method of Disposition	(WIIC)	20b. Place of Disp		ou way	Date		c. Location - City of		_
Baltimore,	S		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cre	matory or other place						
ᆵ	it. Perintentiant	П	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Liebnes 	10		w Memoria			/2004	Sykesvil	le, MD	_
Ba	permit. Page Department of Important: if any injury or once.				B	urrier-Ou	een Fu	neral	Direct	ors, P.A	• • • • • • • • • • • • • • • • • • • •	
			23a. Part1. Enter the disease, or complic	cations that caused	the death. Do not er	212 W. 01 nter the mode of dyin	ng, such as ca	ardiac or res	piratory arres	t,	Approximate	
	The law requires that the death certificate be executed with the death certificate be executed with the attending physician and mapped as should be detached for use as the buriat-transit at the certification.		shock, or heart failure. List only on Immediate Cause (Final	e cause on each lin	ne.	40.00		alix			Interval Between Onset and Death	
1			disease or condition resulting in death)	Due to (or ass	consequence of):	trear	c FC	2000			1	_
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		Jer	Sequentially list conditions. ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o. as a	a consequence of).	1						
		Examiner	Cause (Disease or riquiry that initiated events c.									
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9	leath certific attending p	O I	IF FEMALE:	20 If you guitagma	of programmy							
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal death 3	☐Ectopic pregnancy	y			23d. Date of d Month	elivery Day Year	
	by the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	(inte or death 3	□ Offier (specify)						
of Vital Records, P.O.	res fhat t igned by be detad		Part II. Other significant conditions con	tributing to death bu	ut not resulting in the	underlying cause giv	ren in Part I.		23e. Did toba	cco use contribute	to the cause of death?	
ds	uires r sign ld be	q p	chanic Ren	2 for	okali				1 ☐ Yes	2 No 3 1	Probably 4 Dunknown	
03	w requir	Completed by							24a. Was an	24b. Were	autopsy findings available	
Re	he lav e has age 2 :							_	autopsy performe	ed? death?		
tal	ilcian: Th certificate rector, pag	a	25. Was case referred to medical				26. Place o		1 ☐ Yes 2 L eck only one	No 1 Ye	2010	_
>	Physician: r this certifica ral director,	To B	examiner? 1 Yes 2 No	lospital:	int 2 ☐ ER/Outpatie	ent 3 DOA Oth				ce 6 ☐Other (Sp	ecify)	
10	ding Physician: The h. h. After this certificate ha funeral director, page		27. Manner of Death	28a. Date of Injur	ry 28b. Time	of 28c. injui	ry at			injury occurred		
Ö	death. ctor: Af y the fur	atlo	1 Natural 5 Pending investigation				Yes 2 □ N	0				
Division	or Attens after deatl Director:	Certification;	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							(Street and Number or Rural Route Number, own, State)		
	itel o											
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical			of my knowledge, dea examination and/or i							
	thin 2 the or the	Med	29b. Signature and title of certifier	and manner sta	1100.	29c. Licens	se number		290	d. Date signed (Mo	nth, Day, Year)	_
	£ ₹ ₹ %		> afwish	PASE_		De	1705	5		4-26-	04	
	/X/		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type							_
	1 /.		m. PANSURIY		malco		, W	restr	ninste	2 mi	21157	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		-	ph				
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			For State Registrar	State	of Marylar		artment o <i>rtificate d</i>			1ental I		20	01.	13307
			Decedent's Name (First, Middle)	de, Last)			tinoate	or Death		2. Date o		J. No.	U 4	3. Time of Death
4	Physic /Medi		Charlotte L.	Ensor						Month		Day 23 2	Year 2004	10:17 PM
	Examir		4a. Fecility Name (If not institution	on, give street and n	umber)		4b. City, Tow	m, or Location	of Death	,,,,,,,	-		y of Death	10.171
			4511 White Av				Baltim					N/A		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖔 F	7. Age (In yrs.	* * *	If Under 1 Ye Months Da	ear If Under tys Hours		8. Date of (Month	Day, Y	(ear)	9. Birthp Cour	place (State or Foreign
	Director		219-36-0320 Usual Residence of Decedent		65	Yrs.				Oct.	2,	1938	Tenne	essee
	/land iow		10a. State 10b. Count	у	10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Mar.	tor	MD N/A		Ba	ltimor	-							1 XYes 2 No
	with the Maryland a or 28a-f show Le notified at	Director	10e. Street and Number				10f. Zip Coo	de			100	. Citizen of	What Cour	ntry?
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	ours after death w at', or itams 23a Exartiner must	Funeral	11. Marital Status	Armed F			Was Decedent f Yes, specify (of Hispanic Or Cuban, Mexica	rigin? (Sp	ecify Yes or Rican, etc.	r No-		ce - Americ	
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21215-0036	72 hours after "natural", or ita olical Examine	edt		d Year or	Dates:	16a Dece	dent's Usual Oc	cupation			16			
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<u>ya</u>	Ments Ments Brkec	인	Frank Gree	ene				Rer	na E	elle				
Maryland	2 sho and is ma		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Str	eet and Numb	er or Rura	il Route Nu	m <i>ber,</i> C	ity or Town	, State, Zip	Code)
	as 1 and 2 should b of Health and Ments i itam 27 is marked r other traumatic e		Paula Jo Ensc	r / c	laughter	2842	Cub Hi	ll Road						
Baltimore,	it of H If ita		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from		lace of Dispo emetery, cren	sition (Name of natory or other	place)		ate	20	c. Location	· City or To	wn, State
ţ	parmit. Pages Department of I Important: If its any injury or of		'4 □Doration 5 □ Other (-	Dula		.ey Mem G		-	/04		imoni		
Bal	parmit. Departr Importa any inj		21. Signature of Funeral Service	Cognosio /		_	Name and Ad		,	11		1050 \		
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ı		İ	shock, or heart failure. Lis Immediate Cause (Final	t only one cause on	each line.	i. Do not sin	er the mode of	uying, such as	Gardiac	i respirator	y arrest	1		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Dua ta	500									Mes
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cor	> 0 20	Completed									-			
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tal	an: T	Ö	25. Was case referred to medica	st .				00.0	/ D !	1 ☐ Ye	s 20		1 ☐ Yes	2 🗆 No
of Vital	ding Physician: The lav h. After this certificate has funeral director, page 2	To B	examiner? 1 Tes 2 No	Hospital:	Inpatient 2	ER/Outpatien	3 DOA	Other: 4 Nu		(Check on	<i>ly one)</i> esidenci	6 TO#6	er (Specify)	
סר	19 Ph ter th		27. Manner of Death	28a. Date		28b. Time of Injury	28c. In					njury occur		
io	Attanding ir death. actor: After by the fune	atlo	Z _ / tooldont	gation	ist, Bay roar,	Injury		Yes 2	No					
Division	f or Attandi after death. Diractor: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 280. Place	e of Injury - At ho ling, etc. (Specify	me, farm, stre	et, factory, offic	> 0	2	8f. Location	n (Stree Town, S	t and Numb	er or Rural	Route Number,
	ital or af ral D ral D	S										ŕ		
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	To the Hospital or Attand within 24 hours after death To tha Funaral Diractor: . completely filled in by the f	Med	29b. Signature and title of certifie	andmar	ner stated.			ense number,						
	£ ₹ 8		Mar	(amis	W		250. Lice	34521			290.	Date signer	(MONTH, D	ay, rear)
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	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Signat	ure								
	Registr	ar	APR 2 8 2004	1 Sene	a f	1 Ac	ake							

			For	State of Marylan	d / Department of Healt		iene 2001. 13300
			1 - State Ragistrar		Certificate of Dea	th B	eg. No. 2004 10050
	-81		1. Decedent's Name (First, Middle, La.	st)		2. Date of Dea Month	Dani Vana
	Physic		DETRICK	DAMAR	FAIRLEY	April	26 2004 1958 4
0	/Med Exami		4a. Fecility Name (If not institution, give	e street and number)	4b. City, Town, or Locat	ion of Death	4c. County of Deeth
	Exami	Hei		KINS HOSP	ITAI BAI	TIMORE	NIA
	Formula		5. Social Security Number 6. S		last birthday) If Under 1 Year If Un	der 24 Hrs. 8. Date of Birth	
1	Funeral Director	_		X M 2□F	Yrs. Months Days Hou	ider 24 Hrs. 8. Date of Birth (Month, Dey	2,2003 MARYLAND
	Director		Usual Residence of Decedent			1 00,100	7
	fand ow		10a. State 10b. County	10c. Cit	y, Town or Location	mt.	10d. Inside City Limits
0.	Mary	ō	MARVLAND N	1/4	BAITIM	ORE CITY	1 X Yes 2 □ No
1	the 28a	e C	10e. Street and Number		10f. Zip Code	/	log. Citizen of What Country?
9	n 72 hours after death with the Maryland n 72 hours after death with the Maryland natural; or Itams 23a or 28a-f ahow edical Examiner must be notified at	Funeral Director	547 HALF	MILE COUR	7 21	201	11-5A.
7	eath	era	11. Marital Status	12. Was Decedent Ever in U			14. Race - American Indian,
11:	ter d Itan	Ę,	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗷 No		rican, Puerto Rican, etc.)	Black, White, etc.
7 6	Ir, or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No Spe	city:	Specify: BIACK
1 - N	thor thor	ed	15. Decedent's Ed	ducation	16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
Mi		ojet	(Specify only highest gra	ade completed)	(Give kind of work done during life. DO NOT use retired)	most of working	
2	within ene.	Completed	Efernentary/Secondary (0-12)	College (1-4or 5+)	NIA		NIA
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2	od to do	Be			Λ	LIMAVIA	FAIRLEY
1	ie, ividi yldilu K.i.K. s 1 and 2 should be filed withi Health and Mentat Hygiene. Itam 27 le marked other than other traumatic avent, itam	To	19a, Informant's Name/Relationship (Type Print)	19b. Mailing Address (Street and Nu	imber or Rural Route Numbe	
E C.	12 show and 7 lem		A/ 1 44 C V		(547 411 11)	E COURT BI	
01	s 1 and f Health Itam 27 other tr		20a. Method of Disposition	LLEY (MOTHER)	Place of Disposition (Name of	Date	9270, HD, 2/20/ 20c. Location - City or Town, State
- X	ges 1		1 Burial 2 Cremation 3	'	cemetery, crematory or other place)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
4	mit. Pag vartment ortent: injury		*4 □Donation 5 □ Other (Specif		ZION CEME. CHABYLAND	0.05-03-04	LANSDOWNE HD.
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	3		231. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	th. Do not enter the mode of dying, such	h as cardiac or respiratory are	III I I I I I I I I I I I I I I I I I
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				partment of Health and Nertificate of Death		iene _{9. No.} 2004	13390
	Physic		Decedent's Name (First, Middle, Last) Edward Arnold Fox, Sr.		2. Date of Deat Month		3. Time of Death 7:35 A M
	/Medi Examii		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1-2	4c. County of Death	
-		A gar	2986 West Friends Road	Annapolis		Anne Aru	
Ĺ	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 217–12–7611 7. Mg M 2 F 80 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 11-4-19	9. Birth Cour 923 To	
	yland		10a, State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	e Mar	ctor	Maryland Anne Arundel Annar	olis			1 ☐ Yes 2XXVo
	vith th	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
	eath v	Funerai	2986 West Friends Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Historia Origin 2 (Sp.	asitu Vaa as Na	USA 14. Race - Americ	and Indian
Maryland 21215-0036	72 hours after death with the Maryland insturer; or teme 23a or 28a-f show dical Exacting must be notified at	by	1 Never Married 2 Marned 1 1 Yes 2 No 1 Yes 2 No 1 Yes ar Dates: 1943-46	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, Specify: Whi	etc.
2-0	hin 72 hours af e. en "netural", or M. dical Exervi	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation e kind of work done during most of work	ina	16b. Kind of Business/Ind	dustry
121	d within piene. r then	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	ing		
9	be filed v ntal Hygie od other t	e Co	12th Ornam 17. Father's Name (First, Middle, Last)	nental Iron Worker	e (First Middle A	Construct	ion
lan	S a b	To Be	Harvey E. Fox		a C. Arno		
ary	2 should and Men ie marke aumatic	-		ing Address (Street and Number or Rura			Code)
	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic		l sewas				
Baltimore,	m O - L		20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of practory or other place)	Date 2	Oc. Location - City or To	wn, State
ţ	then tmen tant: ijury		'4 □Donation 5 □Other (Specify) Lakemont	Cemetery 4-26		Davidsonvi]	
Bal	permit. Page Department of Important: If eny injury or once.		21. Signal of Funeral Service Ideensee	2. Name and Address of Facility Ge	orge P.	Kalas Funer	al Home
-y-	4		23a. Part1. Enter the disease, or complications that caused the death. Do not en	2973 Solomons Isla			Approximate
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ers Dementa			Interval Between Onset and Death
8760,	death certificate be executed e attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
.O. Box 6	death certif e attending id for use as	by Physician/Med		□Ectopic pregnancy □ Other (specify)	_	23d. Date of delive Month	ry Day Year
٥.	res that igned b	y P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
rds	w require been sig should b	ed b	INSULIN DEPENDENT DIABLITES	MELLITUS	1 🗆 Yes	2 No 3 Proba	ably 4 Unknown
Division of Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed			24a. Was an autopsy perform	prior to comed? death?	sy findings available apletion of cause of
Vit?	Physician: r this certificatal director, i	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
ō	Phys rthis ral di	- To	1 ☐ Yes 2 ☐ No ☐ No ☐ I ☐ Inpatient 2 ☐ ER/Outpatient 27. Manger of Teath 28a. Date of Injury 28b. Time o		ne 5 X Residen 28d. Describe how	ce 6 Other (Specify,)
lon	Attending ir death. ector: After by the fune	atlor	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No	ou. Describe now	injury occurred	
Divis	To the Hospital or Attending Physician: The law within 24 burns after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specity)		28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or within 24 hours after to the Funeral Diruccompletely filled in I	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cau ad at the time, date	se(s) and manner as sta e and place, and due to	ited, the cause(s)
Ì	To the within 2 To the complet	×	29b. Signature and title of certifier	29a, License number	290	d. Date signed (Month, D	ay, Year)
	/Ŏ				00 ANN	An with	2140
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DHI	MH 17 Rev 1/20	-	APR 2 8 2004	M .			
			ORIGIN				

RPD	775	1 - For State Registrar		Otate C	i marytar		rtificate of	Health a <i>Death</i>	and Mer		. No.2 0	04	13401
Dhusi		1. Decedent's Nan	ne (First, Middle,	Last)						Date of Death		Year	3. Time of Death
Physic /Med			ENNETH	PAIGE	FOUNTA	IN				April 2		4	0050 A N
Exami	ner			give street and nu Isor Mill			4b. City, Town, Baltimo		of Death		4c. County		
Funera Director		5. Social Security 557-73-0		6. Sex 1XXM 2□F	7. Age (In yrs. 2	last birthday) 2 Yrs.	If Under 1 Yea Months Days		Min.	Date of Birth (Month, Day,)	(ear) 1982	Cour	lace (State or Foreig stry) RYLAND
and *		Usual Residence of	of Decedent		10c. Cit	ty, Town or Lo	ocation					1	Od. Inside City Limits
Maryla	ō	MARYLAND	N/A				IMORE						1 XYes 2 □ N
r 28e	Director	10e. Street and No					10f. Zip Code			100	g. Citizen of W	hat Cour	ntry?
23a c	alD	4018	CLIFTON	AVENUE				216			U.S.A.		
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 Is marked other than "natural; or Items 23a or 28e-f show other traumatic event, It & Maryland Eraniner must be notified at	by Funeral		ried 2 Marrie	Armed Fo	2 %∑\ N∘ ve		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2XXN			Yes or No- an, etc.)	Black	- Americ k, White, BLA	
2 hour	led t		15. Decedent's	s Education	, dies.	16a. Dece	dent's Usual Occi	upation		16	6b. Kind of Bu	siness/Inc	dustry
e filed within 72 at Hygiene. I other than "nat	Completed	Elementary/Sec 12th g	ondary (0-12)	grade completed) College (1-4or 5+)		kind of work don DO NOT use retir nemploye		t of working		N/A		
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2 should be and Mental Is marked craumatic even	မ	LEON FR	ANK FOUN			10h Maili	ng Address (Stree			LIA PAI		Cinto Zin	Codel
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permit. Pages 1 and 2 Department of Health s Importent: If item 27 li eny injury or other tra once.	Ħ	20a. Method of Di	•			Place of Dispo	osition (Name of matory or other pi		Date		Oc. Location ·		
Page: nent o int: If			2 ☐ Cremation 5 ☐ Other (Sp.	3 □Removal from <i>ecify)</i>	State	-	CEMETER)4-30-	04 WC	ODLAWN	, MA	RYLAND
permit. Departn Importe eny inju		21. Constant of F	uneral Service L	icensee	m	WI	2. Name and Add LLIAM C	ress of Eacility BROWN	COMMUI	NITY FU	NERAL	HOME	P.A.
#Q = # 9	(Mark	es M.	complications that only one cause on			206 W NO						Approximate
Physician /Medica Examine		Immediate Cause disease or condit resulting in death Sequentially list of if any, leading to	onditions	Due to	(or as a consec		ies						Onset and Death
executed an and irial-transit	Examiner	if any, leading to cause. Enter Und cause (Disease of that initiated even resulting in death)	derlying of mijuly ts) Last	c	(or as a consec	quence of):							
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ificate be er g physician as the buria		IF FEMALE:									22d Date		ery
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State of Manyland / Department of Health and Mantal Hydiana

			For State	State o	f Maryland		artment of rtificate o						
			Registrar 1. Decedent's Name (First, Middle,	Last)			Timodic o	Death		2. Date of Dea		004	3. Time of Death
	Physici				ETTING					Month APRIL	Day 20 '	Year 2004	5:33P. M
	/Medic Examin		4a. Facility Name (If not institution,	give street and nur	mber)		4b. City, Town	, or Location	of Death	12.1(12.1)		unty of Death	
			JOHNS HOPKINS BA	YVIEW MED			BALTI					N/A	
	Funeral			6. Sex VXM 2□F	7. Age (In yrs. I. 47	ast birthday) Yrs.	Months Day		Min.	8. Date of Birth Month Day 1ay 25,	1856	9. Birth	place (State or Foreign Intry) y I a nd
	Director		215-56-2536 Usual Residence of Decedent	٨٨	47					nay 20,	1550	mar.	yrana
	yland		10a. State 10b. County	<u> </u>	10c. City	, Town or Lo	ocation						10d. Inside City Limits
	B Mar	ctor	Maryland N/A		Ba	ltimo	re						XX Yes 2□No
	h with th	ai Director	3129 Chesterfiel	d Avenue			10f. Zip Code	21213		1		of What Cou SA	intry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Medical Examiner was be notified at	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Miniorced	12. Was Dece Armed Fo 1 (1) Yes If Yes, Giv Year or D		5	Was Decedent of If Yes, specify Co	uban, Mexica	in, Puerto F	cify Yes or No- Rican, etc.)		Race - Amer Black, White ecity:	
21215-0036	hin 72 ho s. in "natul Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1	-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use ret	ne <i>auri</i> na mo	st of workir	ng		of Business/Ir	
212	filed with Hygiene other tha	Com		2			Security					urity	Agency
land	ild be filk lental Hy rkad oth ric event	To Be	17. Father's Name (First, Middle, L Anton William Fe							(First, Middle, . Ny Irr	Maiden Sui	тате)	
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event, Ite Mance.		19a Informant's Name/Relationsh Anton Wm. Fettin	ip <i>(Typ</i> e, <i>Print)</i> Ig Jr	Brothe	19b. Maili r 40	ng Address (Stre 8 01d 0r	et and Numb Chard	Road	Baltimo	r, City or To	wn, State, Zi Maryla	nd 21229
ore,	of Hei		20a. Method of Disposition XX Burial 2 □ Cremation	3 □Removal from	State	emetery, cre	osition (Name of matory or other p					ion - City or T	
Ĕ	Pa Junt		`4 □ Donation 5 □ Other (Sp		Dru		dge Ceme						, Maryland
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service L	icensee Ken	akes	2	2. Name and Add			hell-Wied Road Balt			Home Inc. nd 21212
			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that only one cause on e	aused the death ach line.	h. Do not en	ter the mode of o	tying, such a	s cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	- a. Mu	utiple	11/1	UVICS						
	/Medical . Examiner		resulting in death)	Due to	(or as a ¢onsequ	uence of):							
		e	Sequentially list conditions, if any, leading to immediate	b	(or as a consequ	uence of):					· · · · · · · · ·		
	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.									
o,	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to	(or as a consequ	uence of):							
8760,	cate be	dicai		d									
.O. Box 6	attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live b	tcome of pregna birth 2 Fetal nant at time of do own	Ideath 3	□Ectopic pregna □ Other (specify)				23d	. Date of delive Month	very Day Year
Δ.	that the done of the dotached		Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	underlying cause	given in Part	H.	23e. Did to	bacco use	contribute to	the cause of death?
rds	w requires that s been signed to should be deta	q pa								1□Y	es 2	lo 3□Pro	bably 4 Unknown
Records,	The law re ate has bee page 2 sho	Completed by								24a. Was a autop: perfor	sy	4b. Were aut prior to co death? 1 X Yes	opsy findings available ompletion of cause of
Vital		BeC	25. Was case referred to medical					26. Plac	ce of Death	(Check only or			
of V	S S	To	examiner? 1 XYes 2 □ No	Hospital: 1 🗆	Inpatient 2	*FVOutpatie	nt 3 DOA			ne 5□ Resid			ify)
n o	ing Ph After th uneral		27. Manner of Death 1 □Natural 5 □ Pending	1 / 1 / 2	of Injury th, Day Year)	28b. Time of Injury		njury at Vork?	, -	28d. Describe h	ow injury or	STUCK	by motor
Division	death death stor: /	Certification:	2 Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be	of Injury - At he	5: 45	treet, factory, office		(No	28f. Location (S	treet and N	lumber or Rui	ral Route Number,
Div	after Direction by	ertif	4 Homicide determi	build	ing, etc. (Specif	rect			10	City or Tow	n, State)	1. Pa	Himore MD
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only one)	g Physicien: To the Exeminer: On the b and man	hest of my kno	wledge dea	th occurred at the	e time, date a ly opinion, de	and place, a eath occurre	and due to the dead at the time, o	ause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	ro the vithin ro the comple	Me	29b. Signature and title of certifier		00.		29c. Lice	ense number	r	2	29d. Date s	igned (Month	. Day, Year)
	. , , , ,		Potri (lionie	-tall	al +	D (O.C.M.	Ε.	A	PRIL	21,200	4
-	10		30 Name and address of person v	who completed cau	D.II.	n 23a) (Type							01001
	St	ate	31. Date filed (Month, Day Year)	32. F	Registrar's Signa	ature	1 11 Pen	n Stre	et, B	altimor	e, Ma	ryland	1 21201
	Regist		APR	2 8 2004	And all all appears	1 , 1 mm	Brech						

Name (First, Middle, L ny Fritz me (If not institution, gi	ast)								
4						2. Date of D Month	Day	Year	3. Time of Death
me (if not institution, a				~		AF'R:		2004	
	Medical C	Center		ty, Iown, o	Tows		1	nty of Deat Balt	n imore
0.3601	Sex 7. Age 1	(In yrs. last	birthday) If Und Yrs. Month:	der 1 Year s Days	If Under 24 Hr Hours Mir	8. Date of B (Month, D Dec 29	irth lay, Year) , 1936	9. Birt Co VA	hplace (State or Foreignatry)
10b. County		10c. City, To	own or Location			,			10d. Inside City Limit
Baltimo	ore	Balti	imore						1 □ Yes 2 🗗
d Number amon Ct. A	pt. 1A		No.	Zip Code 236			10g. Citizen United		•
ntus Married 2☐ Married ved 4☐Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1		dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or N irto Rican, etc.)		Race - Ame Black, White ecify: Whit	
15. Decedent's E (Specify only highest g	Education trade completed)	16	6a. Decedent's Us (Give kind of v	sual Occup work done	pation during most of width	orking	16b. Kind o	f Business/	Industry
/Secondary (0-12)	College (1-4or 5-	+) N	iife. DO NOT Iurse (RN		d)	·	Health	ı Care	•
ame (First, Middle, Las	st)			• ,	18. Mother's Na	ame (First, Middle	e, Maiden Sum	name)	
lton Colvir	ı				Mildred	Harrov	V		
t's Name/Relationship	(Type, Print)	1:	9b. Mailing Addre	ss (Street	and Number or F	Ru <i>ral Route N</i> umi	ber, City or To	wn, State, Z	(ip Code)
Morrison/D	aughter		323 Knoll			Westfie:	ld, NJ	07090	
of Disposition I 2 Cremation 3 tion 5 Other (Spec		1 .	of Disposition (Natery, crematory of apeake C		1	Apr 27 2004	20c. Location Beltsv		
Funeral Service Lice	ensee Moe	0986				neral Al res Driv			e, MD
ir heart failure. List onli ause (Final ndition sath) ist conditions, to immediate underlying se or injury wents aath) Last	a. Multiple to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a d.	e. RGAN S a consequence a consequence	SYSTEM Deports on the contract of the contract						Approximate Interval Between Onset and Death
edent pregnant st 12 months? 2 M No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 9 ☐ Unknown	2 Fetal dea			,			Date of deli Month	very Day Year
ignificant conditions	contributing to death bu	t not resulting	g in the underlying	g cause giv	en in Part I.		tobacco use co		the cause of death?
						24a. Was auto perf 1 🗆 Yes	s an 24 opsy ormed? 2 No	b. Were au prior to death? 1 Yes	topsy findings availabl ompletion of cause of 2) No
referred to medical	Hospital:			Oth	ac	eath (Check only			
2 No Death al 5 □ Pending ent investigation	28a. D te of Injury (Month, Day		Outpatient 3 [] [D. Time of Injury M	28c. Injur Wor	4 🗀 Nursing	Home 5 ☐ Res 28d. Describe	how injury occ		ify)
de 6 Could not cide determine			farm, street, facto	ory, office		28f. Location City or To	(Street and Number)	m <i>ber or R</i> u	ral Route Number,
1X Certifying P 2 Medical Exa	aminer: On the basis of	examination a	lge, death occurre and/or investigation	ed at the tir	me, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
and title of certifier	- //	~)	2	9c. Licens	e number				
2000 address of person who	o completed cause of de	eath (Item 23a	a) (Type, Print)	D 30	263		04-	23-6	4
	O. of W ^{PO} S. County Mr. a Project	200,200,1	ER DRI	UF T	ามราง	MORVIC	ND 21	21714	
IS KHOO	771 II / 15 IZ			- man	~* · · · · · · · · · · · · · · · · · · ·	F 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		- HE SH	
re	re and title of certifier	only 2 Medical Examiner: On the basis of and manner states and title of certifier and daddress of person who completed cause of de	only 2 Medical Examiner: On the basis of examination and manner stated.	only 2 Medical Examiner: On the basis of examination and/or investigation and title of certifier and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print)	and title of certifier 29c. Licens and address of person who completed cause of death (Item 23a) (Type, Print)	and title of certifier and daddress of person who completed cause of death (Item 23a) (Type, Print) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occarrie and title of certifier 29c. License number D 30263	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated. 29c. License number D 30263 and address of person who completed cause of death (Item 23a) (Type, Print) CIS KHOO M. D. 7601 OSLER DRIVE TOWSON, MARYLE	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated. 29c. License number 29d. Date sign of address of person who completed cause of death (Item 23a) (Type, Print) 21S KHOO M. D. 7601 OSER DRIVE TOWSON, MARYLAND 21.	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated. 29c. License number 29d. Date signed (Month) 230263 deaddress of person who completed cause of death (Item 23a) (Type, Print)

		For State	State of Ma	ryland / D	t Indelible Ink epartment of I Certificate of	Health and I	Mental Hy	giene	ole.
Physici		1. Decedent's Name (First, Middle, Las Mary Lee Fei	ı) Llinger		ocramoate or	Dealit	2. Date of Dea Month April	Day	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	K-206	4b. City, Town,	or Location of Death		4c. County	
Funeral Director		5. Social Security Number 6. Se 220-24-8444		(In yrs. last birtl	nday) If Under 1 Year Months Days		8. Date of Birt (Month, Da Sept. 7,	v. Year)	9. Birthplace (State or Foreign Country) Maryland
Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor	re	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with the 23a or 28	ai Director	10e. Street and Number 2525 Pot Springs	Road Apt.k	(- 206	10f. Zip Code 21093			10g. Citizen of W	/hat Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "netural", or Items 23a or 28e-f show appringing or other traumatic event, the Medical Everal arrival be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ WO If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cul		pecify Yes or No o Rican, etc.)	- 14. Race Black Specify	e - American Indian, k, White, etc. : White
ithin 72 horne. ne. han "netur	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)		-)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	e during most of wor	king	16b. Kind of Bu	
d be filed v ental Hygie ked other ti	To Be Co	12 17. Father's Name (First, Middle, Last) Fordyce Campbell		110	me Maker	18. Mother's Nan	ne (First, Middle, Buschb	Maiden Sumam	Hame _{e)}
nd 2 shoul alth and M 27 is mark	_	19a. Informant's Name/Relationship (7	Type, Pnnt)		Mailing Address (Stree	et and Number or Ru	ral Route Numbe	er, City or Town,	
Pages 1 and of Herman of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 🛣 Other (Specify	Removal from State	20b. Place of cemetery	Disposition (Name of crematory or other plants	ace)	Date	20c. Location -	City or Town, State n, Maryland
permit. Departition of the point of the poin		21. Signature of Fundral Service Licen 23a. Park. Enter the disease, or comp	le le		Ruck Tows	on Funera		Inc.Tows	O York Road
Physician / Medical Examiner behaviorable by physician with physician physician with principle of the principle of the principle of the physician with the physician of the phys	dicai Examiner	shock, or heart failure. List only of the shock or heart failure. List only of the shock or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	e. Life Trop Consequence of trop	ey Failn he Let	w)	Selves		Interval Between Onset and Death
The Coldas, T.O. BOX 6001 The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date Mor	e of delivery hth Day Year
quires that	by	Part II. Dther significant conditions of	ontributing to death bu	t not resulting in	the underlying cause g	iven in Part I.	23e. Did to	Ł _	ibute to the cause of death? 3 Probably 4 Unknown
The lay	Completed						24a. Was autop perfo 1 Yes	rmped? d	Vere autopsy findings available rior to completion of cause of eath?
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day		ime of 28c. Injury	ther: 4 Nursing H		nne) dence 6 ⊟Othe now injury occurre	
DIVISI	Certification:	3 Suicide 6 Could not by determined	e 28e. Place of Injubuilding, etc	ry - At home, far (Specify)	m, street, factory, office	9	28f. Location (S City or Tox		er or Rural Route Number,
To the Hospital or At within 24 hours after or To the Funerel Directompletely filled in by	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best on the basis of and manner state	examination and	d/or investigation, in my	opinion, death occu	rred at the time,	date and place, a	and due to the cause(s)
To t with To t	A	29b. Signature and title of certifier	dry P	· 10.	9 3	34 & 30		0 H	26 OH
YU		30. Name and address of person who was chance with the chance	-y COUL N	· Caro	Type, Print)	theloans	leurala,	gy Bul	to_m, 20.87
St Regist	ate rar		8 2004	r's Signature	A Sound	وع			

DOD 04/25/2004 TOD 8:01 AM

Mary Feilinger

		For State	State of Marylan		artment of H			ene a. No. 2001	. 12101
Physicia	an	Registrar Decedent's Name (First, Middle, Last M O S II G	FELS/		unouto or		2. Date of Death Month	Day Year 25 2004	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	2(71/4		r Location of Deat	h	4c. County of Deat	h
	8	NORTHWEST HO		last hirthday		TOWN A	8. Date of Birth	BALTIM	
Funeral Director		5. Social Security Number 6. S 055-44-7048	ex 7. Age (In yrs. 55		Months Days	Hours Min.	8. Date of Birth (Month, Day,) AUG. 6, 1	948	hplace (State or Foreign untry) POLAND
and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Maryl	tor	MD BAL	TIMORE	PIK	ESVILLE				1 ☐ Yes 2 ☑ No
vith the	Director	10e. Street and Number			10f. Zip Code	21200		g. Citizen of What Co	untry?
Teath v	Funeral	3312 MARNAT ROAL	12. Was Decedent Ever in U	.S. 13.	Was Decedent of F	21208 dispanic Origin? (S	pecify Yes or No-	U.S.A. 14. Race - Ame	
ite; INIAI yialiu ZIZIO-000 stand 2 should be lited within 72 hours after death with the Maryland it mad Mental Hygiene. It math and Mental Hygiene. other treumatic event, the Madical Examiner must be notified at	by Fur	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cubing 1 ☐ Yes 2 ☑ No	an, мехісап, Риеп <i>Specify:</i>	o Rican, etc.)	Black, Whit	e, etc. WHITE
2 hour		15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	pation		6b. Kind of Business/	
within 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		DEL TOTON	
filed within Hygiene.	Be Co	17. Father's Name (First, Middle, Last)	5+	KA	BBI	18. Mother's Nar	ne (First, Middle, Ma	RELIGION aiden Sumame)	
if y latifice Z i Z should be filed within the Mental Hygiene. Marked other then matic event, the Mental Hygiene.	To B	JOSEPH		FELS		MALKA			FELDMAN
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship (DINA FELSMAN / N					ALTIMORE,	City or Town, State, 2 MD 21208	(ip Code)
is 1 and 20 Health itam 27 other tr		20a. Method of Disposition	20b. F	-	sition (Name of natory or other plai		ALC: U.S. C.	Oc. Location - City or	Town, State
Peges Iment of I tant: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y) TZ	EMECH	SEDEK VE	SHOMREI		DUNDALI	
Datumore, permit. Peges 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service Licer	attle		2. Name and Addre	-		ON & BROS	., INC. , MD 21208
HERE.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.		A STATE OF THE OWNER, THE PARTY OF THE PARTY				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a. ENN STA(SE RI	ENAL P	ISEASC	£		Onset and Death
/Medical Examiner			b. SEPS						
D #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as a conseq	ue ice oi).					
BOX 00100, eath certificate be executed attending physicien and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					
ute be e sysicien ne buris	Ical E		d						
A od Sertifica ding ph	ed .	IF FEMALE:	23c. If yes, outcome of pregna	incv				23d. Date of del	NAD!
I NECOLUS, T.O. BOX 801000. The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	<i>'</i>		Month	Day Year
at the day the etache	Phys	9 Unknown	9∐ Unknown	ulkina in Aba		an in Dani I	23a Did toba	cco use contribute to	the cause of death?
vequires that the deben signed by the should be detached	ρ	Part II. Other significant conditions of	ontributing to death but not res	aiting in the u	ndenying cause giv	en in Part I.		2 □ No 3 □ Pr	
aw req	mpleted						24a. Was an autopsy	24b. Were au	topsy findings available
din Ol Vital ned ding Physician: The lav h. After this certificate has funeral director, page 2	Com						performe	death?	2 □ No
Physiclan: r this certifical	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※No	Hospital: 1 ★ npatient 2 □	ER/Outpatier	nt 3 DOA Oth		ith (Check only one)	ce 6 □Other (Spec	rifu)
ng Phy ter this	H	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe how		201/
Mtending death. ctor: Afte	catle	2 Accident investigation 3 Suicide 6 Could not b	e 38e Place of loung. At he	ome farm str		Yes 2 □ No	28f Location (Stre	et and Number or Ru	ral Route Number
al or A safter al Direction by	Certification:	4 Homicide determined	building, etc. (Specif		cot, lactory, critico		City or Town,	State)	
To the Hospital or Attending within 24 hours after death of the Funeral Director: After completely filled in by the fune	edical (nysician: To the best of my known of examina						
To the within 2 Fo the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	290	f. Date signed (Monti	n, Day, Year)
/	ц		M.D.		P57	722	P	PRIL 25	2004
5		30. Name and address of person who				4104167	AAA (47.30	21133	
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture		, Nymous I	MN, MD	21(3)	
Registr	ar	APR 2 8 2004	penera	0 1	parks				

			1- For State of Maryl Registrar		partment of Health and ertificate of Death	Mental Hygier	2004 134113
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) Ruby A. Fergusor 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cer		4b. City, Town, or Location of Dea	AP'RIL	3. Time of Death 23, 2004 71: 200 M 4c. County of Death Baltimore
	Funeral Director			yrs. last birthday Yrs.		8. Date of Birth	9. Birthplace (State or Foreign
	death with the Maryland ms 23s or 28s-f show	Director	Maryland Baltimore 10e. Street and Number	Cato	n SVIII e	10g. (10d. Inside City Limits 1 X Yes 2 □ No Citizen of What Country?
9		Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces?		Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer		14. Race - American Indian, Black, White, etc.
21215-0036	within 72 hours after ene. than "naturel", or ite	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece	adent's Usual Occupation a kind of work done during most of wo	rking 16b.	Specify: Black Kind of Business/Industry
Maryland 21	ould be filed wi Mental Hygien arked other th atto event, the	To Be Con	17. Father's Name (First, Middle, Last) Ruben Barrack	Keg	18 Mother's Na Mar	ne (First, Middle, Maidle) Tha V	lue PointNsg. Home en sumame) 'eney
	es 1 and 2 shore of Health and N If Item 27 Is man or other trauma		19a. Informant's Name/Relationship (Type, Print) (Son) Mr. Milton Ferguson 20a. Method of Disposition 1 Burial 2 **Coremation 3 Removal from State	Db. Place of Dispo	ing Address (Street and Number or R. S N	rth Rd.	y or Town, State, Zip Code) Patto, Md. 21228 Location - City or Town, State
Baltimore,	permit. Pages Department of Importent: If it any injury or o once.			reen M	Ount Crematory 4/2 2. Name and Address of Earlity oseph L. Russ 1	Funeral Hi	med. 21216
3	Physician /Medical		23a. Pany Enter the disease, or complications that caused the shoot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition pure to (or as a conditi	VAL FAI		c or respiratory arrest,	Approximate Interval Between Onset and Death DAYS
7	Examiner ind transit	Examiner		Sequence of).	ERYTHEMATOSUS		YEARS 7 YEARS
68760,	death certificate be executed e attending physician and id for use as the burial-transit	dical	d. DIABETES	MELLIT	rus		
P.O. Box	that the death certifica ed by the attending ph detached for use as t	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pre	Fetal death 3 E of death 5 E	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, I	requires	þ	Part II. Other significant conditions contributing to death but not HYPERTENSION	resulting in the u	ınderlying cause given in Part I.		ouse contribute to the cause of death? 2X No 3 Probably 4 Unknown
		Be Completed	25. Was case referred to medical examiner?			autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 22 No
Division of \	I or Attending Physicien: after death, Director: After this certifical in by the funeral director,	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of Injury		ome 5 Residence 28d. Describe how inju	
Divi	To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by i		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spectroffice) 29a. Certifier (Check only 2 Medical Examiner: On the basis of example)	ecify)knowledge_death	h occurred at the time, date and place	City or Town, Sta	s) and manner as stated
	To the H within 24 To the F complete	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated. 29b. Signature and title of certifier	ination and/or in	29c. License number D 25886		ate signed (Month, Day, Year)
	Sta Registra		30. Name and address of person who completed cause of death (I	OSLER		IARYLAND S	21204

			1 - For State Registrar	State of Marylan	•	artment of F rtificate of		F	Reg. No.	2004	
	Physicia	an	Decedent's Name (First, Middle, Last					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	MICHAEL GAIN 4a. Facility Name (If not institution, give			4b. City. Town, o	r Location of F	April	12,2	County of Deeth	5:35 P M
£	Examin	er	Prince George's		r	Cheve		, oatii		ince Geo	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year	If Under 24			9. Birth	place (State or Foreign
	Director		578-66-9108	□ M 2□ F 53	Yrs.	Months Days	Hours	Min. (Month, Day Ap ri 1	24,1	950 Per	nnsy1vania
	pur *		Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Aaryla Peto Petol	ō			reenbe						1 TxYes 2 □ No
	28a-	Director	MD Prince G	eorge s G	reembe	10f. Zip Code			10g. Citiz	en of What Cou	intry?
	3a or	Ö	7828 Handover P	arkway, #T2		207	70			USA	
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin an. Mexican. P	? (Specify Yes or No- uerto Rican, etc.)	1	4. Race - Amer Black, White	
9	or its		1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,			Lack
Ş	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I and Mental Hygiene is marked other then "naturel", or litems 23a or 28a-f show aumatic event, the Madical Examinar must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occup	ation		16h Kin	d of Business/li	
5	in 72	ojete	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of	working	TOO. KIII	C OI DUSINGSS/II	loustry
212	with giene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Prin	ting Cle	rk				
פַ	e filer al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden S	Sumame)	
<u>a</u>	Menta Menta arked	70	Clifford Gaines				Nina	Mae Goode			
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic		19a. Informant's Name/Relationship (E .			or Rural Route Numbe			
	ss 1 and of Health item 27		Nina M. Goode -					l.,NE, Wash		ation - City or T	
000	Pages 1 nent of h ant: If ite ury or ot		20a. Method of Disposition 1	Hemovai from State		osition (Name of matory or other pla on Nation		17/04		land, N	
altimore,	그 분준 중 .		* 4 □ Donation 5 □ Other (Specify 21. Signature Funeral Service Licer	4							
Ba	Depariment Deparement of the police of the p		21. Signature - une cal service Elcer	200				Latney's I e.,NW, Wash			
10.0	75 3		23a. Parti Enter the disease, or com shock, or heart failure. List only	plications that caused the death						Jon, Do	Approximate Interval Between
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying	a. Fulminant Due to (or as a conseq b. Sepsis Due to (or as a conseq	Hepati						Onset and Death
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rds, P.	w requires that been signed by should be deta		Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	underlying cause gr	ven in Part I.		bacco us 'es 2□		the cause of death?
al Reco		Completed						24a. Was a autop perfor	sv	24b. Were aut prior to o death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of 2 No
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o	Phys this ral dir	<u>٩</u>	1 ☐ Yes 2 🖾 No 27. Manner of Death	142 Inpatient 2	ER/Outpatie	III 3 DOA	4 🔲 Nursi	ng Home 5 Resid			ify)
on	ding I h. After funer	ţ	1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	Injury	₩o	rk? Yes 2⊡No			00001100	
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	To the Hospital or within 24 hours afte To the Funeral Dirk completely filled in I	Medical (ysician: To the best of my kno niner: On the basis of examina and manner stated.							
	To t To t	Σ	29b. Signature and Itle of certification	120		29c. Licens				signed (Month,	
			1/49	VS		D	45471		Apri	1 13,20	U4
	30		30. Name and address of reson who Yeheyis Negussie		n 23a) (Type, Hospit	al Drive,	Cheve	rly, MD			100-
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa		hearth B					

		1	Registrar Decedent's Nar	ne (First, Middle,	Last)			ertificate (<u>Doar</u>		2. Date of D	Reg. No. C.	004	3. Time of De
Physic /Medi			HERMAN			·		GO	LD		APRIL	25 Day	2004	
Exami				(If not institution, g	10000	number)		4b. City, Tow		on of Death	1		ounty of Dea	
Funeral		5.	218-22-55 218-22-1	mber 6	Sex		n yrs. last birthday) If Under 1 Y		der 24 Hrs.	8. Date of B (Month, D		9. Bii	rthplece (State or Fo
Director		Ü	Isuel Residence	of Decedent	X		95 Yrs.				12/13/	1909		PA
28a-f show	or	1	0a. State	BALTIMO	NDE		Oc. City, Town or L PIKESVILI							10d. Inside City L
ms 23a or 28a-f show	irec	10	0e. Street and N		/KL		LIKESATE	10f. Zip Co	de			10g. Citizer	n of What C	ountry?
23a	rai	L	1 STONE	HENGE CI		# 4		2120				U.S		
rall, or ita Exercitive	by Funeral Director	1		rried 2 X Married	Armed 1 ☐ Ye	ecedent Eve Forces? es 2 No Give r Dates:	r in U.S. 13.	Was Decedent if Yes, specify			pecify Yes or No Rican, etc.)		Black, Whi	erican Indian, ite, etc. ITE
*natural".	leted		(Spe	15. Decedent's ecify only highest		nd)	(Give	edent's Usual Or e kind of work do DO NOT use re	one during n	nost of wor	king	16b. Kind	of Business	/Industry
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and Mental Hygie is marked other ti reumatic event, IL.	P	1		Name/Relationship	(Type, Print)			ing Address (St.			ral Route Num	ber, City or To		
f Health a item 27 is other tra		_	JANICE	GOLD / W	IIFE			TONEHEN		CLE #		ESVILLI	E, MD	21208
variment of Hi ortant: If itan injury or oth		20		sposition Cremation 3 5 Other (Spe		m State	20b. Place of Disp cemetery, cre HAR SINA	ematory or other	place)	04/2	Date 27/2004			Town, State
Department Important: If any injury o		2	21. Signature of	uneral Service Lic	ensee	1.1	2	2. Name and A	ddress of Fa	cility COL	LEVIN	SON & I	RDAS	TNC
D 2 6 0		2	23a. Pert1. Enter shock, or he	the disease, or co ant failure. List on	omplications than by one cause o	at caused the	e death. Do not en	8900_RE	LSTERS	TOWN	RD. PI	KESVILI	LE, MI	Approximate Interval Between
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DHMH 17 Rev 1/2001

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Amend Item 1 per FH, 830,04/28/04dhb
State of Maryland / Department of Health and Mental Hygiene
1. State Amend Item 18,19a per InF., 6831,05/06/04dhb Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Dagny Lorriane Gallego **Physician** /Medical acility Name (If not institution, give street and number) Location of Death 4c. County of Death Examiner 0 MOVE If Under 24 Hrs. f Under 1 Year 8. Date of Birth (Month, Day, Year) 09/30/1946 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days Hours 1 ☐ M 2 🔀 F 57 220-50-1172 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f ahow Examiner must be notified at MD TYOYes 2 No n/a Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 211 B Rodgers Forge Road 21212 "natural", or Items 23a USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vaned of Health and Mental Hygiene.
sant: If item 27 Is marked other than "natural", or Items 23, and other fraumatic event, its Medical Evannor muty or other fraumatic event, its Medical Evannor muty. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse 12 Medical 4+ Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be -Dagny Stenholm Beatrice Dagny Stenholm John A. Ceplickas ပ 19a Informant's Name/Relationship *(Type, Print)* **Beatrice Dagny Ceplickas** - Dagny Ceplickas, Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Eagle Harbor S. Laurel, Maryland 20724 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Meadowridge Mem. Park 04/28/2004 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Funeral Service Licenses 50 war 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 10
9 Unknown for Year Month Dav 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown signed I significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes Division of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ainpatient ٩ 1 Tes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 2 🗌 No death. 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) completed cause Hmue, 31. Date filed (Mon 32. Registrar's Signature State Registrar

		For State Registrar	State of Maryla		tificate of E			_{2. No.} 20	04 1340
Physicia /Medic	al	Decedent's Name (First, Middle, Last) Alma May Gernand A. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	2. Date of Death Month April		3. Time of Death 3:00 A M
Examin	er	Edenton Retirement	Community		Freder	ick			erick
Funeral Director		5. Social Security Number 220-03-2364 Usual Residence of Decedent	7. Age (In yrs 8	s. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	19 18	9. Birthplece (State or Foreign Mary Pand
e Maryland a-f ehow	ctor	10a. State 10b. County Maryland Frederi		City, Town or Lo Frederi					10d. Inside City Limits 1 1 Yes 2 □ No
3a or 28	I Director	10é. Street and Number 5849 Genesis Lane			10f. Zip Code 21703		10	g. Citizen of W USA	hat Country?
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. It is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Exams at must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Married 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White
within 72 ho lene. than "naturi Ins Medical E	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decec (Give life. I	dent's Usual Occupa kind of work done di DO NOT use retired) Wife	tion uring most of work	ing	Bb. Kind of Bus	iness/Industry
m - 0 2	To Be Co	17. Father's Name (First, Middle, Last) Robert W. Burrie	r			Lillie		nite	
nd 2 sho alth and 27 is mu r traum		19a. Informant's Name/Relationship (Type Robert E. Gernand/s	•	19b. Mailir 9586	y Address (Street a) Woodland	nd Number or Run I Dr. Wo	odsboro,	City or Town, S	State, Zip Code) 1798
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ፟ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cren	sition (Name of natory or other place im Cemeter	, ,	2007		idge, Md.
permit. Departm Imports any inju		21. Si, atue IF ral Service License	2. Xar 26	4-1	Name and Address 802 Liber				
death certificate be executed National State Control of the Contr	dical Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	CRESS equence of): (K) N SY equence of):	IVE T		TIA	1,	Approximate Interval Between Onset and Death
the death certificate y the attending phys ched for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 □	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
		Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	derlying cause giver	n in Part I.			oute to the cause of death?
	e Completed	25. Was case referred to medical				00 Pl	24a. Was an autopsy performe 1 Yes 2	pr	ere autopsy findings availablior to completion of cause of ath? Yes 2 No
ing Phys Mer this Ineral di	ertification; To B	examiner? 1 Yes 2 No H 27. Manner of D ath 18 Natural 5 Pending investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	t 3 DOA Other 28c. Injury : Work?	4 Nursing Ho	7.00		Asseri)sted Livi
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the th	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre hify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
e Hospi 24 hou ie Funer	Medicai	29a. Certifier 1X Certifying Phys (Check only one) 2 Medicel Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occurr	and due to the cau ad at the time, date	se(s) and man a and place, ar	ner as stated. Id due to the cause(s)
Vithiu To th comp	Me	29b. Signature and title of certifier	~ Mh		29c. License	number	29d	Date signed	(Month, Day, Year)
, ng 1		30. Name and address of person who cor			1				

ORIGINAL

			1 - For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artmer rtificat	nt of He	ealth and Death		Reg	ene 200	4 13410
70	Physici /Medic	al	Decedent's Name (First, Middle, Last) DONALD As Exciting Name (If set institution, sixes)	HUNTER		4b Ciby	Town or	Logation of Do		Date of Death Month April	Day Year 19 2004 4c. County of Dea	3. Time of Death 6:15 P M
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	Director		388-28-9543	M 2□F 77	Yrs.	Months	Days	Hours M	in. J	uly 11	1926 Wisc	consin
	the Maryla 28a-f shov	rector	MD Prince Ge			hever	1y			100	. Citizen of What C	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with	al DI	3001 Hospital Dr	ive			0785				U.S.A.	,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'le Medical Examiner must be notified at Once.	by Funeral Director		2. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Dece If Yes, spe 1 Yes	77	spanic Origin? I, Mexican, Pu Specify:	(Specif erto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Whi Specify: W	
215-0	ithin 72 ho nen *natur e Wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	edent's Usu e kind of wo DO NOT u	rk done di	tion uring most of v	vorking	16	b. Kind of Business	/Industry
Maryland 21215-0036	d be filed w antal Hygier ted other th	Be	17. Father's Name (First, Middle, Last) Morton R. Hunter	5+	At	torny		18. Mother's N		First, Middle, Ma.	Private	
	ind 2 shoul aith and Me 27 is mark or traumati	To	19a. Informant's Name/Relationship (Type Victoria S. Wrigh:					nd Number or	Rural R	oute Number, C	ity or Town, State, Carolina	
Baltimore,	Pages 1 annount of He ant: If item ury or other		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐R: 4 ☐Donation—5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cre prest H	ome C	other place eme .	5/	Date 4/20	004 Mi	. Location - City or Language . 1	Wisconsin
Balt	permit. Departr Import		21. Signature of Fund ral Service License			/4/4	Lando	over Ro	ad 1	. Jenkir Landover	ns Funera , Maryla	1 Home
9 9 1	Physician /Medical		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the de e cause on each line. Sepsis Due to (or as a conse		ter the mod	le of dying	, such as card	iac or re	espiratory arrest		Approximate Interval Between Onset and Death
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8760,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of);							
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rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions con Chronic Resp			inderlying o	ause giver	n in Part I.			_	o the cause of death?
Division of Vital Records,	The law require rate has been single 2 should t	Completed	Cerebrovascu	lar Accident					-	24a. Was an autopsy performed 1 Yes 2 🔀	prior to death?	utopsy findings available completion of cause of
ita	iician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of D	eath (C	hack only one)	12.100	28-110
×	Physician: this certific al director.	To	1 □ Yes 2 🙀 No	ospital: 1 ☑ Inpatient 2 [ER/Outpatie			4 [] INUISING	Home	5 Residence	e 6 □Other (Spe	cify)
sion	tanding leath. tor: After the funer	Certification:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o	М		at P es 2 □ No		. Describe how		
DIA	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			alaka e e de l'e		City or Town, S		
	the Hos in 24 ho the Fun pletely f	edical	one) 2 Medical Exemin	ician: To the best of my kr er: On the basis of examinand manner stated.	nation and/or in	n occurred ivestigation	at the time , in my opi	nion, death oc	curred a	at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and fittle of certifier	14/7	MI		D/6	number 73		29d.	Date signed (Mont	•
	5		30. Name and address of person who could rever the Revathy Morthy				d Che	verly,	Mar	yland 2	0785	
4	Sta Registr	_	31. Date filed (Month, Day, Year) APR 2 8 2004	32. Registrar's Sign	nature	200 M						

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	- 8	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
Physician /Medica		ROSETTA, HUNT		APRIL	5 2000	+ 2:12 PM
Examine		4a. Facility Name (If not institution, give street and number) VNIVERSITY OF MARYAND, 22 SGREENE F	by, Town, or Location of Death		4c. County of Deat	th
Funeral Director	_		der 1 Year If Under 24 Hrs. Is Days Hours Min.	8. Date of Birth (Month, Day, Ye) Dec 25,	9. Birt 1942	hplace (State or Foreign buntry) UNK
P	- H	Usual Residence of Decedent				
ehow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Y Yes 2 □ No
with the Mar	2	MD Baltimore		140-	022	
uth with the 23a or 2	9	106. Street and Number 1677 Vincent Court	Zip Code 21223	rog.	Citizen of What Co USA	ountry?
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene if it item 27 is marked other than "natural", or itame 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	רבי	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De- Armed Forces? unk 1 \(\text{ Yes} \) s 2 \(\text{ No} \) \(\text{ No} \) 18. Was De-	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: 1	
Maryland 21215-0036 td 2 should be lifed within 72 hours aff th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exam. To Be Commissed by E	nubleten	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk 16a. Decedent's U (Give kind of life. DO NOT life. DO NOT life. DO NOT life. DO NOT life. DO NOT life.	work done during most of worki	unk 16b	. Kind of Business/	Industry unk
and 212 d be filed with nital Hygiene ced other the	מ	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name	(First, Middle, Maid	den Sumame)	unk
i, Marylan and 2 should be auth and Mental n 27 is marked of ier traumatic eve	-		ess (Street and Number or Rura Greene Street I			
Baltimore, IN Department of Health Department of Health Mportant: If tiem 27 my injury or other tr		20a. Method of Disposition 1	lame of C r other place)	Date 20c	. Location - City or	Town, State
Baltimo permit. Page Department of Important: If any injury or 2002.			and Address of Facilities and more, MD 21201		altimore	Street
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Physician /Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):				,
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Of Vital Records, Physician: The law requires to this certificate has been signed the city, page 2 should be completed by	naidillo			24a. Was an autopsy performad	prior to death?	itopsy findings available completion of cause of
Vital F	U	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
Of V Physic this ce al direc	2	Hospital: 1 Impatient 2 ER/Outpatient 3	DOA Other: 4 Nursing Hor	me 5 Residence	e 6 □Other (Spec	cify)
Affer Paris		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	
DIVISION C Septiel or Attending P hours after death. Innerel Director: After ty filled in by the funera	ermica	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Ru tate)	ural Route Number,
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To the within To the compl			29c. License number AU4176435WI		Date signed (Monti	•
	- 1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMEEL WASAN, WWNERSITY OF MARY LAND,				
State		31. Date filed (Month, Day, Year) 32. Registrar's Signature	, , , , ,	1 42 - 300-1		
Registra		ADD 2 8 2004 Beneva & A	an W			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylar		artment of		and Mental F	lygiene Reg. No.	Z 13 11 15	13412
70	Physici		Decedent's Name (First, Middle, Last) Rena Howa	_				2. Date of Month April	Death Day 24		3. Time of Death 12:45A M
7	/Medio Examir		4e. Fecility Name (If not institution, give			4b. City, Town	n, or Location of			County of Dea	
	Exami		356 Chaptico S.			Laure	1		Ar	nne Aru	ndel
7	Funeral		5. Social Security Number 6. Sex	- 3Z		If Under 1 Ye Months Day		24 Hrs. 8. Date of (Month,	Birth Day Year) 27, 19	9. Bir	thplace (State or Foreign ountry) W YORK
ŀ.	Director		229-34-3298	/	2 Yrs.			Oct.	27, 19	931 Ne	w york
	/land		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	a-f et	ctor	MD Anne Arui	ndel L	aurel						1 □ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Cod	е		10g. Citi	zen of What Co	ountry?
	ath w	ra	356 Chaptico S			2072			US		
980	a within 72 hours after death with the Maryland liene. r than "natural", or iteme 23a or 28a-1 ehow the Medical Examiner must be natified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	was Decedent of Yes, specify C		gin? (Specify Yes or , Puerto Rican, etc.)		14. Race - Ame Black, Whi Specify:	
Maryland 21215-0036	within 72 ho ene. than "natur he Weulcal I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Ock kind of work do DO NOT use rel	ne durina most	t of working	16b. Kii	nd of Business	/Industry
21	e filed wi Il Hygien other th		10	Ø	Hor	memaker	40.14.15	4 N (5 1 A 6)		own Hom	e
and	& da b	Be	17. Father's Name (First, Middle, Last) Edward A. Thompson	2				or's Name (First, Midd	dle, Maiden	Sumame)	
Ž	2 should be and Menta is marked sumatic ev	ဥ	19a. Informant's Name/Relationship (Ty		19b. Mailir	na Address (Stre	-	a E. Reid or or Rural Route Nur	nber. City o	r Town. State.	Zip Code)
	りもびき		Judy M. Rowe / Day			-		oad, Brool			
Jre,	of Heal		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other)		Date		cation - City or	
Ē	Page nent ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	te of I			/27/2004	Silv	er Spr	ing, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		21. Signature of Funeral Service Licenso	irt M01338		. Name and Ad 7601 Sat		rieck ri			Inc. vland 20707
Ě	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	in the caused the dea the cause on each line. The union. Due to (or as a consect of the consec	quence of):	2	an un		y arrest,		Approximate Interval Between Onset and Death I west
x 68760,	death certificate be executed e attending physician and d for use as the burial-transit	/Medical Examiner	resulting in death) Last	Due to (or as a consect. 3c. If yes, outcome of pregn						22d Date of de	
P.O. Box		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Feta 4 Pregnant at time of o 9 Unknown	al death 3	Ectopic pregna Other <i>(specify)</i>			-	23d. Date of de Month	Day Year
ecords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the ur	nderlying cause	given in Part I.	T T		se contribute to ∃No 3⊟Pi	the cause of death?
α	The ate h	Completed							topsy normed?	24b. Were ad prior to death?	utopsy findings available completion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				of Death (Check onl			
of		- T	1 Yes 2 No	1 ☐ Inpatient 2 ☐	ER/Outpatien 28b. Time of	t 3 DOA	nurvat	rsing Home 5 Re			cify)
O	Attending F r death. ector: After by the funer	ţi	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	Injury		njury at Work? □ Yes 2 □ N			00001100	
Division of Vital	al or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stro fy)	eet, factory, offic	се	28f. Location City or	(Street and Town, State)	d Number or Ri	ural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, death ation and/or inv	n occurred at the vestigation, in m	e time, date and iy opinion, deat	d place, and due to the	ne cause(s) e, date and	and manner as place, and due	s stated. a to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	0 0			ense number			e signed (Mont	
	1		h. Quitin	hagle no		_	23800	•		1 26,	
	12		30. Name and address of person who co	impleted cause of death (Item	n 23a) (Type, 2445 Ca	Print)	tr., 22	S. Greere	St.,	Baltimo	mp 21201
į	Sta Registi		31. Date 14 P. R. 2. 8y. 20104	32. Registrar's Sign.	aturb D	onke	,				

		1	Amend Item 2	3a,PtI,per	State of Dr., G830, C	Marylar 4/28/04	nd / Depa idhb <i>Cei</i>	artment of F Tificate of	lealth a Death	and Mer	ntal Hy	giene Reg. No. 2 (104	13413
	Physic	an	1. Decedent's Name	e (First, Middle, Lu	ast)	", "	11	1		2.	Dete of De		Year, 3	3. Time of Death
- and	Physici /Medi		PAU.	L >	0 Sept)	Hug	hes_			PRIL	15 2	004	855 AM
ر	Examir	ner	4a Eacility Name (/	. 1 /		,	1	100	4b. City, Tov	wn, or Locati		4c. Count	of Deeth	
_			5. Social Security N	ruper 6	Medic Sex, 7.		lest birthdey)	If Under 1 Year	If Under	/	Re Date of Bin	h N/	9 Birthologo	o (State on Ferrier
	Funeral Director		577-30-9		150 M 2□ F	rigo (m yro.	78 Yrs.	Months Deys	Hours	Min.	Date of Bir (Month, De Jar 5	y, Year) 1926	Country)	e (Stete or Foreign
			Usuel Residence of											
	aryler ehow	-	10a. Stete	10b. County			ty, Town or Lo							Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ecto	FL 10e. Street end Nur	Pinell	as	St	. Pete							
	with weith	ā		er St. N	다			10f. Zip Code 33703				10g. Citizen of		
	death	Funeral Director	11. Maritel Status	CI DC. N	12. Was Decede			Vas Decedent of H	lispenic Orig	gin? (Specify	Yes or No		State:	
21215-0020	filed within 72 hours after death with the Marylend Hygiene. ther than "netural", or flems 23a or 28a-f show that the Medical Examiner must be notified at	Ď	1 ☑ Never Marri 3 ☐ Widowed	ed 2 Married 4 Divorced	Armed Force 1 ☑ Yes 2 If Yes, Give Year or Date	□No		Yes, specify Cuba	an, Mexican Specily:	, Puerto Rica	an, etc.)	Bla Specif	ck, White, etc. y: White	
5-0	72 hours "netural",	De la	(Spec	15. Decedent's E			16e. Deced	ent's Usual Occup	ation	of working		16b. Kind of B	usiness/Indust	ry
121	Man vithin	Completed	Elementery/Second		College (1-4d	or 5+)	life. L	OO NOT use retired	d)	o, worning		Educat	ion	
d 2	should be filed withir nd Mentel Hygiene. merked other than imetic event, the M		17. Fether's Neme (First Middle I ast	5+		Teacl	ner	18 Mother	r's Name /Fi	ret Middle	Maiden Suman	nol	
Maryland	S To S	o Be		Vincent					Viol		rsi, Middle, cinell		100)	1
ary.	d 2 should th and Men 7 is marke traumatic	F	19a. Informant's Na				19b. Mailin	g Address (Street					Stete. Zip Coo	de)
	nd 2 lith a 27 li		Ann AuCo	in/Niece				Dover St						
ore,	8 5 = 0	Ī	20a. Method of Disp		7D		lace of Dispos	ition (Name of etory or other place		C	ate	20c. Location		
ij	nit. Pages entment of I ortant: If Its Injury or o			5 ☐ Other (Special	Removal from Sta	te		ke Crema		20	r 17	Beltsv	ille, M	1D
Baltimore,	permit. Page Depertment of Important: If eny Injury or ence.	1	21. Signat w ∌f Fur	neral Service Licer	nsee M	20980	0	Name and Addre Cremation 8717 Gree	n and	Funer	al Al Driv		ves imore,	MD
	BANK		23a. Part1. Enter the shock, or hear	ne diseese, or com	plications thet caus	ed the deet								proximate erval Between
7	Physician /Medical Examiner		Immediate Cause (I disease or condition resulting in death)	Final	400			Ation					Ons	set and Death
	-	liner	recounting in death)		Bowel Of	Due to (o	or es a consequ ION	uence of):						
68760,	eath certificate be executed ettending physicien end for use as the bunal-transit	al Examiner	Sequentially list con if eny, leeding to im cause. Enter Under Cause (Disease or i	nditions, mediate rlying injury	c	Due to (o	r as e consequ	ience of):						
	certificate Iding phys	v/Medical	that initiated events resulting in death) L		d	Due to (or	r as a consequ	ence of):						
Вох	death certi e ettending ed for use a	Physician/M	Dod II. Other elemifi	cent conditions		history and an a	late - to also	4.4.4		7.	001 Did.	•		
0	res thet tha de signed by the e be detached f	hys	Part II. Other signific	cant conditions c	ontributing to deetr	out not rest	uiting in the un	derlying cause give	en in Pert I.			obaccouse co ′es 2⊡No		cause of death? y 4 ☑ Unknown
S, P	gned oe del	by P										20.10	C T TODGOT	- Politaionii
Vital Records,	e lew requires thet tha has been signed by th ge 2 should be detach	Completed								_	24a. Was e perfor		aveilab	eutopsy findings le prior to etion of cause h?
- B	The late he	5									1 □ Y	es 2 KNo	1 □ Ye	s 2 No
/ita	ysician: The is cartificate director, peg	Be	25. Was case referre	ed to medicel	11-3-2-1			100		of Death (Cr	eck only or	те)		
to	S 00	2	1 ☐ Yes 2.00+1 27. Manner of Death		Hospital: 1-1 Inpa		ER/Outpetient		4 - IVUIS			ence 6 □Oth		
	ding I h. After funer	흔	1-DNatural	5 Pending investigation	(Month, L	Dey Year)	28b. Time of Injury	28c. Injun Work	γeι k? Yes 2 □ N		Describe n	ow injury occur	ed	
Division	To the Hospital or Attending Phy within 24 hours after deeth. To the Funerel Director: After thi completally filled in by the funeral	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	9 28e. Place of I	njury - At ho etc. <i>(Specif</i>)	ome, farm, stre	et, factory, office		28f. I	Location (S City or Tow	treet and Numb n, State)	er or Rural Rol	ute Number,
	To the Hospital within 24 hours of the Funerel I completaly filled	edicai C	29a. Certifier (Check only one)	1 ፭r Certifying Ph 2 ☐ Medical Exam	ysician: To the bes niner: On the basis and manner	of examinat	wledge, deeth ion end/or Inve	occurred at the timestigation, in my or	ne, date end pinion, death	plece, end on occurred at	due to the c	euse(s) and ma ate and place, a	nner as steted and due to the	cause(s)
	Within To th		29b. Signature and t	itle of certifier	C +	_ ~		29c. License	number		2	9d. Date signer	(Month, Day,	Year)
	-			11/2	IL 1	e		P17	164)		4-1	5-04	
(341		30. Name and addre		completed cause of	death (Item	23e) (Type, P	rint) 10 N. (FREEN	1e 5th	reet.	Battin	URO MA	2/20/
	Star Registra	te ar	31. Date filed (Month	2 8 2004	32. Regis	trer's Signer	B 4	parks						

\J	.029		1 - For State uppend item#23c	State of Marylan a,27,Per ME,G831,5/	id / Depa /13/06æ	artment of I	lealth and I Death	-	ene2004	13414	
	Physici	an	1. Decedent's Name (First, Middle, La	E				2. Date of Death Month	Day Year	3. Time of Death	
	/Medic		ROBERT	LEE HOU	CHE	NS			5, 2004	1650 P. M	
1	Examir	ier	4a. Facility Name (If not institution, gi			4b. City, Town, o	or Location of Death	1	4c. County of Dea	ath	
			11 North Cather				imore		N	/A	
553	Funeral Director		219-52-5350	Sex 7. Age (In yrs. 129.4 129	(Ast birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day,	Year)	rthplace (State or Foreign country)	
,	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation			/	10d. Inside City Limits	
	ith the Marylar or 28e-f ehow e rotified at	ö	1/4 0 1/4 1/4	1/A		^	= 1100	- n	-:/	1 No 2 No	
	the /	Director	10e, Street and Number			10f. Zip Code	TIHOR		Citizen of What C	ountry?	
	th with 23e or	Ö	11 N CATU	ERINE ST, 15	TFIRE		2122		45,		
	death ms 2	era	11. Marital Status	12. Was Decedent Ever in U.			Hispanic Origin? (Si an, Mexican, Puert		14. Race - Am	· · · · · · · · · · · · · · · · · · ·	
ယ	after or ite	by Funeral	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🗷 No				Rican, etc.)	Black, Wh	te, etc.	
8	ours a		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I∐Yes 2ÂNo	Specify:		Specify: B	ACK	
5-0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "natural", or items 23e or 28e-f ehow aumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	lent's Usual Occup	pation during most of work	king 1	6b. Kind of Business	/Industry	
7	ithin Jen	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	d) -				
2	filed w Hygier other th	Col		MASTERS DEGREE	MA	CHINE	OPERA		LACIN	DRY	
<u>n</u>	be fil ntal H od ott	Be	17. Father's Name (First, Middle, Las					e (First, Middle, M	aiden Sumame)	./	
<u>\$</u>	ould be Mental varked o	2	CLAYTON		UCHE		LRE		KEL	<u>- y</u>	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla tof Health and Mental hygiene. If item 27 is marked other then "natural", or items 23e or 28e-f ehov or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship						City or Town, State,		
	f and the fealth om 27 iner tra		I RENE HOUCH		10 /	Sition (Name of	THERINE	ST. 13	HLTO, H	0,21223	
Ö	ges it of h		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 [Removal from State	emetery, cren	natory or other plac		Date 2	0c. Location - City or →	Town, State	
3altimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra	4	* 4 □ Donation 5 □ Other (Speci	M) AR	BUTU	s Cemer	TERY 05-	01-04 £	PALTIHORI	E HARYLAND	
Bal	permi Depar Impo eny ir		21. Signature of Funeral Service Lice	nsee	22	Name and Addre	iss of Facility	ROWN JK	FUNER	AL HOME 0. 2/1/7	
	40200	\Box	Leston 1	1. William		1140 N	FULTON	AVE. R	ALTO, M		
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Atheroscleroti	c Cardio			or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Examiner		ſ	Due to (or as a consequ	uence of):						
		ē	Sequentially list conditions, any leading to in reclair cause. Enter Underlying Cause (Disease or injury	 Due to (or as a consequ 	aance of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	ate be executed hysician and the burial-transit		resulting in death) Last	c. Due to (or as a consequ	uence of):						
8760,	ate be ex hysician the buria	dical		_ d							
9	tifica ng ph as th	Medi									
Вох	that the death certific ed by the attending p detached for use as	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal 1 Live birth 2 ☐ Fetal		Ectopic pregnancy	,		23d. Date of de	livery	
Э.	he death	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		Other (specify)			Month	Day Year	
P.O.	at the	hy	9 Unknown						Throate.		
	se ge	Completed by Physician/Med	Part II. Other significant conditions	contributing to death but not resu	ulting in the un	derlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
ord	w requir been si should	ted						1 🗆 Yes	2 □ No 3 □ P	obably XXUnknown	
မင	e law r has be je 2 sh	ble						24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of	
8	The ate h page	Con						performe	ed? death? XiNo 1 ☐ Yes		
ita	Attending Physicien: The Ir death. creath. sctor: After this certificate ha	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)			
>	Physic this ce al dire	2	1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3□ DOA Oth	er: 4 🗌 Nursing Ho	me 5 🗆 Residen	ce 6 🕉 ther (Spe	cityAt scene	
0	ding Ph h. After th funeral	ü	27. Manner of Death ↑ ▼Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	y at k?	28d. Describe how	injury occurred		
0	ttendii death. stor: A / the fu	atle	2 Accident investigation	n			Yes 2 ☐ No				
Division of Vital Records,	i or Attencater death Director:	Certification;	3 Suicide 6 Could not be determined		me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,	
Q	itel c rel Di led ir		ony or rown, state)								
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Leave 2 Medical Example 1	nysician: To the best of my know miner: On the basis of examinati and manner stated.	wiedge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)	
	To the within 2 To the complet		29b. Signature and tale of certifier			29c. License O.C.N	e number M. F.	29α λ ν	Date signed (Mont.	h, Day, Year)	
			Theoder M.	King was				_	_		
			30. Name and address of person who THEODOREM. Kin	completed cause of death (Item	23а) (Туре, Р	Print)	Ctroct	D-1+		3 0400-	
			THEODORE M. Kin			TII LEIN	i sireer,	patt1moi	e, Maryla	nd 21201	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 7	32. Registrar's Signat	ure A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 8:50 AM 2004 1920 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Nursing Home If Under 24 Hrs. 6. Sex last birthday 9. Birthplece (Stete or Foreign **Funeral** Days Hours 1 🗆 M Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or itams 23a or 28a-f show any injury or other traumatic event, it is Medical Examination ust be negligible anone. Baltimore 1 Tes 2 No Completed by Funeral Director 10e, Street and Nymber 10f. Zip Code 10g. Citizen of What Country? 4028 USA 21215 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2☐No 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Yes, Give 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Segondary (0-12) College (1-4or 5+) Home Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ or Rural Route Nun 20b. Place of Disposition (Nam cemetery, crematory or of 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Ucens Part. Ene the disease, or complications that caused the death, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dying, such as cardiac or respiratory arrest, Immedia a Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō Day Year Month 5 Other (specify) page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Umez 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 🗆 No 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: Medical Certification; To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title 30. Name and ad c use of death (Item 23a) (Type, Print) Green lemas 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

			1 - State Amend Item 23a,Pti	State of Mary II per MD,683	land / Depa 0 ,04/28/0 4	rtment of h	lealth and Death	Mental Hyg	giene Reg. No. 200	L 131.16
1	Physici	an	1. Decedent's Name (First, Middle, Last) Albert Lo					2. Date of Dea		3. Time of Death 6:15 PM
}	/Medic Examin		4a. Facility Name (If not institution, give str 1190 W. Norther	reet and number)		4b. City, Town, o		th	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 217-01-8575 (20) NUSUAL Residence of Decedent		yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		r, Year) C	rthplace (State or Foreign country)
	Ba-f show	ctor	MD 10b. County N/A	100	City, Town or Loc Bal	timore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
36	s within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23a or 28a-1 show The Madical Evarriner must be rudffield at	by Funeral Director	10e. Street and Number 1190 W. Northern 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Pkwy . A	in U.S. 13. V	10f. Zip Code 2121 Vas Decedent of Fres, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	U . S 14. Race - Am Black, Wh Specify: B1	encan Indian, ite, etc.
21215-0036	swithin 72 jiene. r then "na	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ation	us De	ent's Usual Occup kind of work done ODNOT use ratire OLOGO ing Gro	during most of we Army -	orking Aberdee	an .	s/Industry ions Tech visor
Maryland	2 should be filed and Mental Hygin is marked other raumatic event, I	To Be C	17. Father's Name (First, Middle, Last) Joseph Hawkins				Este]	ame (First, Middle, Lla Samp	son	
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Anthony T. Hawki			g Address <i>(Street</i> oland M			r, City or Town, State, ID 21210	Zip Code)
Baltimore,			20a. Method of Disposition ¹X Burial 2 ☐ Cremation 3 ☐ Rei ¹ 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ob. Place of Dispos Arbutus Park	sition (Name of natory or other pla Memori		Date	20c. Location - City o	
Balti	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licensee			. Name and Addre	ess of Facility N1	utter Fi	uneral Ho	omes, Inc. MD 21216
8760,	Physician //Medical Examiner this private it is the private in th	ledical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, isaumy to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last d.	Due to (or as a co	nsequence of):	Snanc	5			Interval Between Onset and Death
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date of do Month	elivery Day Year
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ō	Attending Physician: Thirdeath. ector: Atter this certificate by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpation 28b. Time of Injury	28c. Inju	ner: 4 🗆 Nursing	+	ne) lence 6 □Other (Sp low injury occurred	ecify)
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)			City or Taw		
	o the Hospital or thin 24 hours after the Funeral Dis mpletely filled in	edical		cian: To the best of mer: On the basis of exa and manner stated.						
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	25		30. Name and address of person who com 31. Date filed (Month, Day, Year)	3º Registrar's	1 419W	Print)	I ST Bu	n nd	4-22-	r, to Gr
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Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last Gertrude Marie H A. Facility Name (If not institution, give	unter		4b. City, Towr	n, or Location of Deatl	2. Date of Dea Month April 2	Day Your	
Funeral Director	CI	612 Foxcroft Dri 5. Social Security Number 6. Se	.ve	. last birthday) Yrs.	Bel A If Under 1 Ye Months Day	ir ar If Under 24 Hrs.	8. Date of Birt	Harfor	rthplace (State or Foreig
D.	or	Usual Residence of Decedent 10a. State 10b. County Md. Harford	10c. C	ity, Town or Lo	cation		Feb. 9	, 1932 1.	10d. Inside City Limits
within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow the Mudical Exantirer must be rigitled at	ai Director	10e. Street and Number 612 Foxcroft Dri			10f. Zip Code	21014		10g. Citizen of What C United Sta	
ours after des rai', or items Examinar m	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puert Ro Specify:	pecify Yes or No- o Rican, etc.)		
within remi	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12 years	cation e completed) College (1-4or 5+)	(Give	DO NOT use ret	ne during most of wor	king	16b. Kind of Business	
d Mental Hyg marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last) Frank B. Kraus 19a. Informant's Name/Relationship (Ty	voa Print)	10b Mailie	a Address (Stra	Irene H	Brinker	Maiden Sumame) r, City or Town, State,	T- 0-41
permit. Fages 1 and 2 should be filed within 72 flouts after death with the marylar Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Modical Examiner must be notified at once.		Stephen Hunter, 20a. Method of Disposition 1 Disposition 1 Donation 5 Other (Specify)	Sr. 20b.	1334 Place of Dispo cemetery, cren		Lynn Court		ir, Md. 210 20c. Location - City of	114 Town, State
Departm Departm Importe any inju		21. Signature of Funeral Service Licens White 23a. Part. Enter the disease, or complete	L. Dauid) 22	Name and Add Schimun 610 W.	tress of Facility ek Funeral MacPhail H	L Home of Road, Bel	f Bel Air, 1 Air, Md.	Inc.
ysicia ne bur	icai Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, have resulting to thim ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or a	Quence of):	Can		or respiratory and		Approximate Interval Between Onset and Death
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sen signed b	ted by PI	Part II. Other significant conditions con	4		derlying cause (given in Part I.	23e. Did to	bacco use contribute to es 2⊠No 3□P	the cause of death?
ate has page 2		Hyperfernia 25. Was case referred to medical	Λ					sy prior to med? death? 2. XNo 1 ☐ Yes	utopsy findings available completion of cause of
ath. pr: After this certificate ha: ne funeral director, page 2	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 Inpatient 2 Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. In	other: 4 Nursing He		ne) ence 6 □Other (Spe ow injury occurred	cify)
un an apparent of Arenauling raystrain. Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	il Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special Special			City or Town			
within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	sician: To the best of my knoter: On the basis of examination and manner stated.	tion and/or inv	estigation, in my	time, date and place, opinion, death occur	red at the time, d	ause(s) and manner as ate and place, and due 19d. Date signed (Mont	to the cause(s)
Stat Registra		30. Name and address of person who company of the c	mpleted cause of death (Iter M 32. Registrar's Sign	5 Mg	Print) ac Phai acks	1 pd	Mel A	in MP	21014

			1 - For State Registrar	State of	of Marylan	d / Depa <i>Cei</i>	artmen rtificate	t of H e <i>of L</i>	ealth a D <i>eath</i>	and M		giene Reg. No.	200	+ 13418
	Physici /Medi		Decedent's Name (First, Middle, William Rober)	t Hobbs							2. Date of De Month April	20, Day	2004	10:00P M
	Examir	ner	4a. Fecility Name (If not institution, 5911 Eurith Av 5. Social Security Number		7. Age (In yrs. i	la et hirthday)		Balti	Location of Lmore	Cit	y 8. Date of Bir			/A
ŀ	Funeral Director		218-03-6192 Usual Residence of Decedent	1 M 2 □ F	90		Months	Days	Hours	Min	(Month, Da August	v. Year)	913 Ma	nthplace (State or Foreign ountry) ryland
more, maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Int: If item 27 is marked other then "natural", or Itams 23a or 28a-1 ahow int: If item 27 is marked other then "natural", or Itams 23a or 28a-1 ahow into other traumatic event. The Medical Examinar must be notified at	To Be Completed by Funeral Director	10a. State 10b. County 10b. County 10b. County 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street Stre	12. Was Dec Armed Fi 1 Types It Ases, Gi Year or Use Education grade completed) College (ast) ton Hobbs p (Type, Print) (Wife) 3 Removal from	edent Ever in U. prces? 2 No ve Dates: 1-4or 5+)	16a. Decec (Give life, L	Was Deceding to the Lorentz of the L	Code 2 No Code 2 No Cocupa A done de retired Cocupa C	specify: tition uring most or 18. Mother Sus ond Number EVENUE	r's Name San S	ng (First, Middle, Schwark Al Route Number	Un 16b. Kir Gas Maiden off or, City or	& Electory Electory Electory & Electory Electory & Elec	tates erican Indian, te, etc. White Vindustry Ctric Zip Code) Town, State
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	h the Ma r 28a-1	irecto	MARYLAND 10e. Street and Number		BALTIA	10f. Zip Code		Ţ	10g. Citiz	zen of What C		
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Maryland	should be and Mental s marked o	ToB	THOMAS MARIC 19a. Informant's Name/Relationship (7)	///////	19b. Mail	ing Address (Street	CATH	HERINE ural Route Numb	er, City or	RE Town, State,	HR Zip Code)	
	1 and 2 Health a em 27 la		COLLEGY H 20a. Method of Disposition	- 170mch	Db. Place of Disp	27 SWA	IN POINT	WAY (MBIA /	AD ZIO	45
Baltimore,	permit. Pages Depertment of H Important: If Its eny injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ *4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cometery, cre	matory or other place	IR L-	26-04	FORE	ST Hi	L, MAR	YLAUD
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rds, P	The law requires that ite has been signed b age 2 should be deta	þ	Part II. Other significant conditions of	entributing to death but no	t resulting in the t	underlying cause give	en in Part I.				o the cause of de robably 4 Dur	
Vital Records,		Completed						24a. Was autor perfo 1 \(\text{Yes}	psy prmed?	prior to death?	utopsy findings as completion of cases	
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1	Rospit 4 hours Funers ely fille	edical (29a. Certifier (Check only one)	vsician: To the best of my iner: On the basis of exa- and manner stated.	knowledge, dea mination and/or ir	th occurred at the time evestigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
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			30. Name and address of person who d	1	MD (Item 23a) (Type	Print)	S-00 JOHNS +	DO KINS	AKR Hosp	11 24 17XL	2004	+
			TYESATTA MASSAQUOL. 31. Date filed (Month, Day, Year)	600 North 32. Registrar's S	WOLFE S	TREET.	BALTIA	AURE.	MAR	YLAND	21287	P
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ORIGINAL

/Medi	ian	1. Decedent's Name (First, Middle, Las	rine	TA	MONO	~ }			;	2. Date of D Month	Da	4 -	ar	3. Time of Death 0 4 10
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CXAIIII	iei	Howard County Gene				1	lumbi		Doguii			oward	204(11	
Funeral Director		213-09-4456	ex □M 2MF	7. Age (In yrs 92	s. last birthday, Yrs.) If Unde Months	er 1 Year Days	If Under 2 Hours	4 Hrs. Min. 1	B. Date of Bi (Month D 0/27/		9.	Birthplace Country Laly	ce (State or Fore
M II		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or L	ocation							10d	Inside City Lin
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or 28	Direc	10e. Street and Number Northe.	Ridge Ro	ad			ip Code					izen of Wha		
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and Men is marks aumatic	J.	19a. Informant's Name/Relationship (7	Type, Print)		19b. Maili	ina Addres	s (Street a			Alagr		or Town, Star	te Zin C	nde)
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45.	8	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final			atii. Do not en	101 1110	na or ayını	g, such as G	ardiac or	respiratory a	arrest,		(2)	pproximate
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month : *Physician 8-10 PM April 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TAGNES HEALTHCARE Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) **Funeral** 12 M 2□F Months Days Hours 216-16-6101 Usual Residence of Decedent Yrs Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or Itams 23c or 28a-f show 1 Yes 2 No MARYLAND Directo 10e. Street and Number 10g. Citizen of What Country? 8 ALTIMORE ST 15A filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1ĂNever Married 2☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No ACK þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UPONT MGRADE othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam 27 is markad othn any liury or other traumatic event 2008. Be EDWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 NARCISSUS AVE DAUGHTER) 20b. Place of Disposition (Name of BALTO, 40, 2/2/5 HAMMONDS Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State NAT'L CEMETERY 05-01-04 LAUREL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility BROW 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Se **Physician** PSIS Unknown /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) the Ö 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records. 3 Probably 4 Uknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate ! 2 No 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Impatient 2 ER/Outpatient Certification: To 3□ DQA Division of After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16695 April 26, 1 OLUMIDE, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BABATUNDE HEALTHCARE BALTIMORE SAINT AGNES 31. Data-filed (Mogth, Day, Year) APR 2 8 2004 32. Registrar's Signature

Registrar

			State of Maryland / Department of Health and No. 1- State of Maryland / Department of Health and No. 1- Registrar ATTN IIIM #IOc PR FH (\$30 2/28/04) Printed to 1 Death 10 11 11 11 11 11 11 11 11 11 11 11 11	Mental Hygie	-	10100
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	Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, Ye	9. Birth Cou	nplace (Stete or Foreign untry)
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	9 7 8	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Grow 1 Yes, Grow 1 Yes or Dates:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
1215-0036	within 72 hours aft ene. than *natural', or the Medical Exam	mpleted	15. Decedent's Education (Specify only highest grade completed) [Specify only highest grade completed) [Specify only highest grade completed] [Give kind of work done during most of work life. DO NOT use retired) [III. DO NOT use retired]	sing 16t	b. Kind of Business/Ir	1dustry
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, Maryland	1 and 2 should Health and Men tem 27 is marke other traumatic	F	19a. Informant's Name/Relationship (Type, Print) LOVICINE JEFFERSON WIFE) 4982 RIGHS CF. UL	ral Route Number, Ci	II ity or Town, State, Zi	D Code)
Baltimore	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr anges.		20a. Method of Disposition 1 Remarks 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) KING PORK 5-3	Date 200	Caltinor	own, State
Balt	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wou 8728 Liberty RD.	ughn C (reene fu stown, p	neral Sric. ND 21133
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	E WE C	~	29b. Signature and title of certifier 29c. License number ###################################	29d. 1	Date signed (Month, MI 26, 2	OD Y
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			1 - For State of Mary		artment of H			ene 200	4 13423
·-	Physici /Medic		1. Decedent's Name (First, Middle, Last) John Janicki				2. Date of Death Month		
	Examir Funeral		4a. Facility Name (If not institution, give street and number) Good Sauaritan 5. Social Security Number 6. Sex 7. Age (In	tospital yrs. last birthday) Yrs.	4b. City, Town, or Batta If Under 1 Year Months Days	MOCE If Under 24 Hrs.	8. Date of Birth (Month, Day, Sept. 14,	4c. County of De Baltim Year) 9. E	eath OFE OTA Birthplace (State or Fereign Country)
	Director		Usual Residence of Decedent	c. City, Town or Lo				1920 Mai	ryland 10d. Inside City Limits
	the Mary 28a-f eh	Director	MD N/A 10e. Street and Number		Balt:	imore City	,	g. Citizen of What	1 ☑ Yes 2 ☐ No
0	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at	Funeral	5818 Benton Heights Avenue 11. Marital Status 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married 12. Was Decedent Ever Armed Forces? 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married	I		spanic Origin? (Spec n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	Black, Wi	
13-00g	n 72 hours after *naturel', or Ite	leted by	3 Widowed 4 Divorced If Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Deced	1 ☐ Yes 2 ☑ No dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of workin	19	Specify: Wh	
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sallimore, Mai	permit. Pages 1 and 2 st Department of Health and mportant: If Item 27 is n any injury or other traun ange.		'4 Donation 5 Other (Specify)	5818 Ob. Place of Disponsion for Place of Disponsion for Pland	Benton He sition (Name of natory or other place Cemetery	4/30/	enue Bali ate 20 2004 I	timore Ma Oc. Location - City o Baltimore	or fown, State Maryland
٥	Physician /Medical Examiner	0.70	23a. Pan1. Enter the disease, or complications in cause the short or heart failure. List only one cause on fine. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition)	death. Do not ente	er the mode of dying		.Itimore,	, Marylan	1 Home d 21206 . Approximate Interval Between Onset and Death
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O. DOX 0	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time 9 □ Unknown	Fetal death 3 [Ectopic pregnancy Other (specify)			23d. Date of d Month	delivery Day Year
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I VII del	nysician Ns certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	Otho	26. Place of Death () ce 6 □Other (Sp	pecify)
VISION OF	ending Physath. or: After this		27. Manner of Death 1 🖫 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Injury Work! M 1 TY	at 28 ? 'es 2 \(\sum No \)	8d. Describe how	injury occurred	
200	tal or Atter safter de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S)	At home, farm, stre pecify)	eet, factory, office	28	8f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
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	J V V	Σ	29b. Signature and title of certifier	If M.	29c. License DOC	number 25867	7/ 290	d. Date signed (Mos 4/25/0	nth, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 0 2004 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale HOS IIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number In yrs. last birthday 9. Birthplace (State or Foreign Country)
Baltimore, Mi **Funeral** Days Hours 10 M 2□F Director Usual Residence of Decedent _10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director 1 ☐ Yes 20 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "--- any injury or other traumette. 21236 u 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No MM/ IYes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2/200 es. Give ar or Dates: Peacettm Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manggemen 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Jol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wite 21236 2 Jack 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Fath Com. '4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heap failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute HOURS /Medical Due to (or as a consequence of): Examiner ANEMI teule Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed bin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and pholeley filled in by the funeral director, page 2 should be detached for use as the burish-transit mobile by the funeral director. that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4⊡Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death Check only one 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours all To the Funeral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) W

DHMH 17 Rev 1/2001

State Registrar SQUARE DR. BAITIMORE Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 28

BIRNBAUM 9000 FRANKlin

32. Registrar's Signature

Mary C. Jones 04-02812 MAN

W.			1- For Unpend Item #23th 27 Maryland (1839) Party and Certificate of Death	Mental Hy	giene 0 0	4 13425
	Physic /Med		1. Decedent's Name (First, Middle, Last) Mary Christina Jones.	2. Date of De Month April		3. Time of Death 2020 P M
30	Exami Funeral		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Franklin Square Hospital Rosedale 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		4c. County of E	Dre Birthplace (State or Foreign
R	Director works		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	8. Date of Bin (Month, Da 12-16	y, Year M	ASSACHUSETTS 10d. Inside City Limits
	ith the Man or 28e-f sh	Director	MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code		10g. Citizen of What	1 Tes 2 No
	er death wil Items 23e c	raiD	3037 Moreland Ave. 21234		UST	4
980	ours after death with the Maryla rat', or items 23e or 28e-f shov Examinar munt by notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Year or Dates:	pecify Yes or No- Rican, etc.)		omerican Indian, Vhite, etc.
21215-0036	illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23e or 28e-f show int, it to Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) From 150 Policy (1-4or 5+)	king	16b. Kind of Busine	
Maryland 2	be de la la la la la la la la la la la la la	To Be C	e sistema in the sist	e (First, Middle,	Maiden Sumame) delain	oherd Center.
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/ elationship (Type, Pr t) 19b. Mailing Address (Street and Number or Rur 20a. Method of Disposition 20b. Place of Disposition (Name of	Hackvi	11e, MD	21234.
Baltimore,	permit, Pages Department of I Important: If ite any injury or of		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	29-04. Actimos	FOREST	HILL MD 21234.
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. Lisy only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of):	or respiratory arr	8800 HHIC est,	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mur) that initiated events			
68760,	tificate be executed ig physician and as the burial-transit	edicai Exa	resulting in death) Last Due to (or as a consequence of): d.			
Вох	Attending Physicien: The law requires that the death certificate be executionable. The state this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transfer.	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 S 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 5 Other (specify)		23d. Date of o	delivery Day Year
ords, P	law requires tha as been signed I 2 should be det	ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		. /	to the cause of death? Probably 4 □Unknown
Division of Vital Records, P.O.	nn: The law ificate has b or. page 2 st	e Completed	25. Was case referred to medical		y prior to death	autopsy findings available o completion of cause of ? es 2 \(\subseteq \text{No}
fVi	nysicle nis cert direct	To B	examiner?		e) once 6 □Other (Sp	necify)
o no	ding Pt h. After th funeral		27 Manner of Death		w injury occurred	ouny
Divisi	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be	28f. Location (St. City or Town	reet and Number or I , State)	Rural Route Number,
	To the Hospital or within 24 hours after the Funeral Dirticompletely filled in Incompletely	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca	use(s) and manner ate and place, and du	as stated. ue to the cause(s)
	To To	2	29b. Signature and title of certified		od. Date signed (Mor	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		April 25,	2004
	Sta	. 6 .	31. Date filed (Month, Day, Year) Registrar's Signature	altimore	, Marylan	d 21201
	Registr	ar	APR 2 8 2004 See & Specific			

			1 - For State Registrar	State of M		/ Depa		t of H	ealth a	and M	lental H	lygien	ne _	04	13	1426
	Physic	ian	1. Decedent's Name (First, Middle, La.								2. Date of	Death				e of Death
	/Medi	cal	John Kenneth Koehler, Sr.											Year Year	3:25	5 A M
	Exami	ner	4a. Fecility Name (If not institution, given Saint Joseph M							VSON		4		ty of Deat	h imore	2
	Funeral Director		216-12-3859	ex 7. A X M 2□F	ge (In yrs. last	birthday) Yrs.	If Under Months		If Under: Hours	24 Hrs. Min.	8. Date of (Month, 02/19	Day, Yea	r) 3		hplace (Sta buntry) rylan	te or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation								10d Insid	e City Limits
	Mary Ined	tor	MD Baltim	ore	Rose	edale										res 2 No
	or 28g	irec	10e. Street and Number		11000		10f. Zip	Code				10g. C	itizen of	What Co	ountry?	
	ath wi	ral	1318 Spring Av	enue			2	1237				U	.S.A	١.		
Maryland 21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23s or 28s-f show 'ns Medicul Eng. it at must be notified at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 XYes 2 ☐ If Yes, Give Year or Dates:	?		Was Deced f Yes, spec 1 ☐ Yes	U.L	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto í	cify Yes or Rican, etc.)	No-	14. Ra	ice - Ame ack, White	nican Indiar e, etc.	1,
2-0	72 ho	Completed by	15. Decedent's Ec (Specify only highest gra	lucation		Sa. Deced	ient's Usua	I Occupa	tion			16b.	Kind of E	Business/		-
21	vithin ne. han	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	kind of woi DO NOT us	se retired)	uring most	or workir	ng					
2	Hygi thar nt, I		11 17. Father's Name (First, Middle, Last)			Sel	f-Emp				(Fine A A 4) -			ry P	lant	
lan	should be tand Mental I s marked or	To Be	Edward N. Koehle								(First, Midd		n Sumai	me)		
ary	es 1 and 2 should b of Health and Ments I Itam 27 is markad r other traumatic e	E	19a. Informant's Name/Relationship (7		1	9b. Mailin	g Address	(Street a			Smit!		or Town	. State. Z	in Code)	
Ž,	and 2 ealth a m 27 is		John K. Koehler	, Jr.							Rose				237	
ore	pes 1 an of Heal of Itam 2 or other		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	20b. Place ceme	of Dispos	sition (Nam	ne of			ate	_			Town, State)
Ë	Pag tment tant:		° 4 ☐ Donation 5 ☐ Other (Specify	')	More	land	Mem.	Gdn	s. 0	4/28	/2004	Ba	altin	more	, Mar	yland
Baltimore,	permit. Pages 1 Department of the Important: if Ita any injury or ot once.		21. Signature of Funeral Service Licen	n Chan	poki	1	1750	Bela.	ir Ro	ad -	King	svill	ı Fu le, I	nera MD	1 Home 21087	e, P.A.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause one cause on each I	d the death. D	o not ente	er the mode	of dying	, such as o	cardiac or	respiratory	arrest,			Approxir Interval	Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a.SEPSIS		_									Onset a	nd Death
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oʻ	cate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as	a consequenc	e of):										
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9	entifica ding ph	/Mec	IF FEMALE:	22a Kwas sutas	-4											
P.O. Box	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		Ectopic pre Other (spe							ite of deli-	very Day	Year
	as Iha gned	by P	Part II. Other significant conditions co	ontributing to death b	out not resulting	j in the un	derlying ca	use giver	in Part I.		23e. Did	tobacco	use cont	tribute to	the cause of	of death?
ord	w require been si should I	ted	DYSPHAGIA								1	Yes 2	X No	3 🗆 Pro	bably 4	∐Unknown
Vital Records,	e law r has be je 2 sh	Completed									24a. Wa	s an	24b. '	Were aut	opsy finding	s available
E	: The cate to page	Con									per	formed? 2 X No		death? 1 🗌 Yes		r cause of
Zi Zi	hysician: The la his certificate ha I director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				4			(Check only					
o	D = 0	: To	1 ☐ Yes 2 X No 27. Manner of Death	1 X Inpatie	ent 2 ER/0	Outpatient Time of			4 🔲 1401 :		e 5 Res				ify)	_
Division of	Attending Ph ar death. actor: After th by Ihe funeral	atior	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	M	lc. Injury a Work? 1 🗀 Ye			od. Describe	now inju	ry occurr	rea		
N S	Atter ar dea actor by lhe	ifice	3 Suicide 6 Could not be determined	286. Place of Inj	28e. Place of Injury - At home, farm, street, factory, office 28						of. Location	(Street ar	nd Numb	er or Rui	al Route N	umber,
ā	tal or rs afte al Dir ed in	Certification:	4 - Hormoldo	building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Medical	29a. Certifying Phy (Check only one)	rsician: To the best iner: On the basis o and manner st	r examination a	ge, death and/or inve	occurred a estigation, i	t the time in my opir	, date and nion, death	place, ar	nd due to the	cause(s , date and) and ma d place, a	anner as s and due s	stated. to the cause	e(s)
	To To I	Σ	29b. Signature and title of certifier				29c.	License r	number			29d. Da	te signed	d (Month,	Day, Year,	
)			Challo	m	/			:588	5			ar	bril	21	1-20	04
1	11		30. Name and address of person who d					, , , ,				1				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	601 01 ar's Signature	SLER	DRI	VE.	TOW	SON,	MAR	YLAN	4D E	2120	4	
	Registr		APR 2 8 2004													
DHM	AH 17 Rev 1/20	001	~ O ZUU4		· Ja	dag.	AP .									

			1 - For State Registrar AMEND TIEM #	State of M	1arylan	d / Depa	artmei	nt of H	lealth	and M		giene	_		13427	
			1. Decedent's Name (First, Middle, La	ast)	· · · ·						2. Date of De	eath Da	v	Yeer	3. Time of Death	
	Physici /Medio		1/04/1/10/10										3	04	21:05 PM	
	Examin		4a. Fecility Name (If not institution, gi	ve street and number	r)			, Town, or				1	. County			
			NOYH AWNMEL	0	N BU						ARUNT					
	Funeral		5. Social Security Number 6. 216-42-3449	Sex 7. A 1 X M 2 □ F		last birthday)	Months Months	or 1 Year Days	Hours	Min	8. Date of Bir (Month, Da	ace (State or Foreign try)				
ы	Director		Usual Residence of Decedent			9 Yrs.			<u> </u>		Dec.15	, 194	14	Berk	ley, CA	
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	0d. Inside City Limits	
	Mary	to	Maryland Anne Ar	undel	Pas	sadena									1 ☐ Yes 2 💢 No	
14	r 288	rec	10e. Street and Number				10f. Z	ip Code				10g. Ci	tizen of V	Vhat Coun	try?	
$\frac{1}{2}$	h with	0	8463 Kenton Road				21	122					USA			
TH	deat	by Funeral Director	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U	.S. 13.	Was Dece	edent of Hi	ispanic Or	rigin? (Spe	cify Yes or No Rican, etc.)	>-		e - Americ		
20	or ite	/Fu	1 ☐ Never Married 2 ☐ Married	1 Tes 2 7					Specify		11041, 0101,			: Whi		
ELVILAW RENCE	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow ite Mudical Esta" iber frant ke nodiffed at	d b	3 Widowed 4 Divorced	Year or Dates	:											
70	natu	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)		16a. Dece (Give	kind of w	onk done o	ation during mos	st of worki	ng	16b. K	ind of Bu	siness/Inc	dustry	
25	withir ane. Ithan	m d	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Associate									Inc	Insurance			
120	Hygie ther ant.	ပိ	17. Father's Name (First, Middle, Las	st)		Jares	733	ocial		er's Name	(First, Middle					
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<u>Z</u>	shoul nari	F	Lawrence Joseph Keen, Sr. Doris Cast Dor											Code)		
KE Baltimore, Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic avant. Its Mudical Exertifies Instal is indiffied at		Marilyn E. Keen	(Spouse)		8463	Kent	on Ro	oad,	Pasad	dena, M	D 21	122			
ē,	s 1 a f Hee itam othe		20a. Method of Disposition		20b. P	Place of Dispo	sition (Na	ame of	(a)		ate	20c. L	ocation -	City or To	wn, Stete	
Ê	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		1 Donation 5 Other (Spec			n Have				April 2	7, 2004	Glen	Bur	nie.	Maryland	
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m	Depa Impo any it		Muschell	Max 2	Long	$\sim 1)$ 3	111	Mount	cain	Doad	Dacad	ona	MD	21122	P.A.	
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γ Division of Vital Records, P.O. Box 68	ding se as	by Physician/Med	IF FEMALE:	23c. If yes, outcom	e of pregna	ancy							23d Dat	e of delive	D/	
B	atter 1 for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)									23d. Date of delivery Month Day Year			
o.	the d y the iched	ıysi	1 Yes 2 No	9□ Unknown				, , , , , , , , , , , , , , , , , , , ,								
₽.	uires that the dea	y Pł	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying	cause give	en in Part	l.	23e. Did 1	obacco	use conti	ibute to th	e cause of death?	
rds	quires n sign										1 🗆	Yes 2	□No	3 Prob	ably 4 Dunknown	
00	w requir s been si should!	jeto									24a. Was		24b. V	Vere autor	osy findings available appletion of cause of	
Re	sician: The law scertificate has b irector, page 2 si	Completed										ormed?		rior to con leath? □ Yes		
tal	an: T	BeC	25. Was case referred to medical		/				26. Plac	e of Death	1 Yes		<u>'</u>	1.62	2 140	
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ivis	r Atte	Certification:	3 Suicide 6 Could not determined	a 286. Place of I	njury - At he	ome, farm, str	eet, facto	ry, office			28f. Location (Street ar	nd Numb	er or Rural	Route Number,	
\$ 0	ital or A irs after ral Directed in by															
\	Hosp 4 hou Fune ely fil	ica	(Check only 2 Medical Exa	Physician: To the bes aminer: On the basis	of examina	wiedge, deat ition and/or in	h occurre vestigatio	d at the time, in my of	ne, date ai	nd place, a	and due to the ed at the time,	cause(s) and ma d place, a	nner as stand due to	ated. the cause(s)	
	To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) 29b. Signature and title of certifier	and manner	stated.			9c. Licens							Dey, Year)	
	To To		Signature and title of certifier	1 11-						0 100		11/	3 3 /	a (revoruri, L	, roar/	
	h		/ /V/aurile M	unght	Laborate //s	- 00-1 (T		1D DI	0056	1009		TL	25/	7_		
	り		30. Name and address of person who	completed cause of	ATT #	ASBULLA	Frint)	0 700	740							
	Sta	ite	31. Date filed (Month, Day, Year)	22. Regis	strar's Signa	ASBUR ature	(P. C.	, 200	10		<u>_</u>					
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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Adam John Kane 20, 0600A April 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8810 Walther Blvd. #1110 Baltimore 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours XXX M 2□ F 87 Yrs. 218-01-0926 Sept.5, 1916 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Carney 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. #1110 21234 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Yes ② XNo Specify: White 3x Widowed 4 ☐ Divorced Specify 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Tester Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Krolczyk Mary Rozanski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Jones (Cousin) 2805 Bluebell Court Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cemetery 4/23/04 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Marvland 21. Si nature if Funeral Service Licensee 22 Name and Address of Facility Miller—Dippel Funeral Home, Inc. 6415 Belair Road Baltimore, Maryland 21206 There is ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 Tes 2 No 3 ☐ Suicide 6 Could not be determined

The law requires that the death certificate be executed P.O. Box 68760, attending p of Vital Records, has paga 2 cartificate director, this funeral Division

Physician /Medical

Examiner

Physician

/Medical

Director

by Funeral

Completed

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Examiner

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Certification: To Be

Medical

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parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Health and Mantal Hygiene. Important: If Hem 27 is marked other than "natural! ~ 1.00 any hiury or other traumentic event

death. I Director: Af id in by the fu fillad in by or A To the Hosp within 24 hou To the Funel completely fi

State Registrar

30. Name and ad andeman 31. Date filed (Month, Day, Year)

APR 2 8 2004

29b. Signature and title of certifie

4 Homicide

29a. Certifier

son who completed cause of death (Item 23a) (Type, Print)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Blud Parkville mo

Walt 0000

32, Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95

		1 - For State Registrar		Maryland / De		nt of H	ealth and	•		e a n	04	13429
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/Medic Examin		4a. Facility Name (If not institution, giv		Apri	April 20, 2004 4:0							
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Funeral Director		5. Social Security Number 6. S 216-01-2156	ex 7. M 2□F	Age (In yrs. last birthd 93 Yrs	Months	or 1 Year Days	If Under 24 H Hours M	in. 8. Date of I (Month, Nov.)	Birth Day, Year,	0	9. Birthple Count Marv	ece (State or Foreign ry) Land
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21215-0036 of within 72 hours att giene. In matural; or art man.		15. Decedent's E. (Specify only highest gra		16a. De	cedent's Usu	ual Occupa	ition	un dern a	16b. K	Cind of Busi	iness/Indi	ustry
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Maryla d 2 should th and Mer 7 Is marke	_	19a. Informant's Name/Relationship (Type, Print)				nd Number or	Rural Route Num	ber, City o	or Town, Si		Code)
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U/20/c Baltimor permit. Pages Department of Important: If it any injury or o		21. Signature Funer Service Licer			22. Name a	nd Addres	s of Facility				е, м	aryland
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Box 68' Box estiticat attending phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	B □Ectopic p					23d. Date of	,	
Jilliam # 4/1 I Records, P.O. Box 68 The law requires that the death certifica tite has been signed by the attending phoage 2 should be detached for use as the	Completed by Physician/Med	1 Yes 2 No	4□Pregnant 9□ Unknown		i□ Other (s _i	pecify)				Month	1 0	ay Year
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Vital F Vital F ician: Th	ပို	25. Was case referred to medical					20 01 (0	1 ☐ Yes	2 110		Yes 2	□ No
N 00 10 =	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Linpa	tient 2 ER/Outpati	 ent 3□ D0	Othor		eath (Check only Home 5 Res		6 □Other	(Specify)	
	L:uo	27. Manner of Death	28a. Date of In (Month, D			28c. Injury : Work?		28d. Describe				
Sewification of Attending Physics Alter the funeral by the funeral	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Ye	es 2 □ No					
or Al	Certification:	4 Homicide determined	289. Place of I	njury - At home, farm, : etc. <i>(Specify)</i>	street, factor	y, office		28f. Location City or To	(Street and own, State,	d Number (or Rural P	Route Number,
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To the withing To the complet	Medicai	one) 29b. Signature and title of certifier	and manner s	stated.		c. License		, a, , o d at 11.0 (11.10		te signed (A		
1 2 8		· archaro	100	el M	A -							
(3)		30. Name and address of person who o	completed cause of	death (Item 23a) (Type	e, Print)	, -			0	/ -		2004 1d 21014
Stat	0	TRUANA 50 31. Date filed (Month, Day, Year)	OD MO	trar's Signature	CHI	180	WILL	E Rd	KE	LAIR	/\	1d 21014
Registra		APR 2 8 2004	Beneda	B A	south							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 222 PM KOPITS 70212 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner BALTIMORE 7002 40th 6 BACTIMORE KESWICK MULTI GARE CAR If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) Nov. 27, 1909 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ XF 217-76-9167 94 Director Hungary Nov. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heath and Mental Hygiene. ent: If item 27 is marked other than "natural", or Items 23a or 28e-f show ury or other traumatic event, the Medical Examiner must be motified at 1 Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3704 N. Charles Street Apt 1406 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by If Yes, Give Year or Dates: Specify Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be မှ <u>Marianne</u> Czaro-Fogarassy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Relationship (Type, Print) 3704 N. Charles St. Apt 1406 Maria Ruggiero Daughter Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Importent: If ite
any injury or of 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp | May 3, 2004 Towson Maryland 21. Signature of Fune al Service Ligensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 Ou York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Somagia months /Medical resulting in death) Due to 'or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Day Year 5 Other (specify) 4☐Pregnant at time of death been signed by the a should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 × 0 0 1 Tyes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed 2 XX0 filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 1 🗌 Yes 2/ZN0 1 Inpatient 2 ER/Outpatient 3□ DOA ■ ursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Hospitel or Attending Patural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 24 hours after death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Function To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number 8 APRIL 27 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. BATTMORE UND 21211 Marios MI) teron 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 8 2004

ORIGINAL

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

of Vital Records, P.O. Box 68769.

Division

		1 - For Amend Item Registrar		## 6830 	/laryland 4/28/0	Depa tas Cei	artment rtificate	of He	ealth a Death			ne.2004	1343		
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/Medic Examir		4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deat									Death 4c. County of Deeth				
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or 28a	Director	10e. Street and Number				-	10f. Zip (Code			10g.	Citizen of What Cou			
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Department Importent: any Injury opice.		21. Signature of Funeral Ser	vice Licensee	the	h							N & BROS. KESVILLE,			
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		_	For State Registrar	State of Ma	arylan		artmen rtificat			nd M		ene g. No 20	04	13432		
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The ate h	page 2	e completed	25. Was case referred to medical			-			00. 81			id?	rior to con eath?	psy findings available apletion of cause of 2 No		
ding Phys	Il direct	0	evaminer?	Hospital: 1 ☐ Inpatier 28a. Date of Injun (Month, Day		ER/Outpatient 28b. Time of Injury		Other	4 ☐ Nursi	ng Hom 28	(Check only one) ie _5—Resident 8d. Describe how)		
the Hospitel or Attending hin 24 hours after death. The Funerel Director: After	Illed in by II	l Cerunication:	3 Suicide 6 Could not be determined	building, etc.	(Specify) ====_					8f. Location (Stre City or Town,	State)		916		
To the Hospory Mithin 24 ho	Completely filled in by		29a. Certifier (Check only one) 29 Medical Exam 29b. Signature and title of certifier	rsician: To the best of iner: On the basis of and manner state	examinati	viedge, death ion and/or inv	estigation, i	t the time in my opi License	nion, death o	occurred	d at the time, date	se(s) and main and place, and place, and place, and place, and place are the signed	nd due to	the cause(s)		
5			30. Name and design of person who co	-(101 hado	ath Iltern	23a) (T) pe. F	Print 12	Buc	evi	- ((+	, and	(.	10	- 10001		
Reg	State gistra	•	APR 2 8 2004	32. Registra	's Signati	y A	lon 1	61								

		-			c. Ensure All	•	•	
1	State	State of Ma	-	•	Health and Mo		0001	
1.0	Registrar Decedent's Name (First, Middle, Last)			Certificate of		Reg. I	Vo. 2001	3 Time of Beath
Dhysician	Catherine Frances	Lynch				APril	24 2004	8:22PM
	Fecility Name (If not institution, give st	11 .0).]	4b. City, Town,	or Location of Death		4c. County of Deat	
5.5	Canklin Squar Social Security Number 7 6. Sex		(In yrs. last birthe	day) If Under 1 Year	dale I Under 24 Hrs.	8. Date of Birth	Baltu	MOTE hplace (State or Foreign
Fulleral		M 211 F	86 Yr	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yee 10/12/191		ryland
	ual Residence of Decedent a. State 10b. County		10c. City, Town	or Location			1 110	10d. Inside City Limits
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Maryland 21215-0036 Maryland 21215-0036 d.2 should be filled within 72 hours after death with the Maryland the and Mental Hygiene. 77 le marked other then "naturel", or Items 23e or 28e-f show traumatic event, the Medical Examitter rount by intillied at To Be Completed by Funeral Director	e. Street and Number		TOLU	10f. Zip Code		10g. (Citizen of What Co	untry?
23e ou La Caraciana de La Cara	5560 Hamlet Lane			33919			U.S.A.	
5 2 E 5	Marital Status 12 1 □ Never Married 2 □ Married	 Was Decedent E Armed Forces? 1 □ Yes 2 10 No. 	ver in U.S.	 Was Decedent of If Yes, specify Cut 	Hispanic Origin? (Spec ban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
036 or all, or Exam	3 X Widowed 4 □ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify: Wh	ite
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within within man	Elementary/Secondary (0-12)	College (1-4or 5-	H)	fe. <i>DO NOT use retire</i> Iomemaker	9 <i>d)</i>		O II	_
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arylar arylar should be and Menta or marked umeric ex umeric ex To B	Christian Lee Han	ley			Ann Win	ifred Dro	ney	
Mary Jand	a. Informant's Name/Relationship (Type				t and Number or Rural			(ip Code)
A SEE	Michael T. Lynch (Method of Disposition	(son)	20b. Place of D	isposition (Name of	Drive - Fa	-	D 2104 Location - City or	
altimore, mit. Pages 1 at portant: If them yi injury or othe	1 XBurial 2 ☐ Cremation 3 ☐ Rei	moval from State		crematory or other pla	cem. 04/28/			
Baltimore Pages 1 Dependent of H Important: If its Important: or ott	Signature of Funeral Service Licensee	0; 1	De. De.	22. Name and Addre	ess of Facility E.	F. Lassah	n Funera	l Home, P.A
O 80 5 5 8	Mostarbasch	Chance		11750 Bela	ir Road - 1	Kingsvill		1087
	 a. Part1. Enter the disease, or complications, or heart failure. List only one mediate Cause (Final 	ations that caused to cause on each line	the death. Do not	enter the mode of dy	ing, such as cardiac or	respiratory arrest.		Approximate Interval Between Onset and Death
Physician, disc	sease or condition a.	C.V.	consequence of)					
Examiner	quentially list conditions b.	Due to (or as a	consequence or)					
D ig Sec	quentially list conditions, b. ny, leading to immediate use. Enter Underlying usa (Ciseusa Crimury)	Due to (or as a	consequence of)					
e a inai	it initiated events c. sulting in death) Last	Due to (or as a	consequence of)					
8 ig ig	d.							
I Records, P.O. Box 68760, The law requires that the death certificate be at the has been signed by the attending physicien bage 2 should be detached for use as the burial completed by Physician/Medical E	FEMALE:							
Boy bath ce attend for use	b. Was decedent pregnant 230 in the past 12 months?	If yes, outcome o	Fetal death	3 Ectopic pregnance	ey .		23d. Date of deli	very Day Year
the de	1 □ Yes 2 No 9 □ Unknown	4□Pregnant at t 9□Unknown	ime of death	5 Other (specify)				,
cords, P.O. wrequires that the de been signed by the should be detached leted by Physic	II. Other significant conditions contr	ibuting to death but	t not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
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Vital Revicion: The favicion: The favicion: The favicion page 2	Was case referred to medical					performed? 1 ☐ Yes 2 🛣 N	lo 1 Yes	2□ No
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T :no	Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		e of 28c. Inju		d. Describe how inj		ny)
Siol tendir Beath. tor: At the fu	2 Accident Investigation 3 Suicide 6 Could not be			M 1	Yes 2□No			
Division of Vital Records, tital or Attending Physician: The faw requires the state death. The Director: After this certificate has been signed in by the funeral director, page 2 should be of Certification: To Be Completed by	4 Homicide determined	28e. Place of Injur building, etc.	y · At home, farm (Specify)	, street, factory, office	28	8f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
	a. Certifier 1 Certifying Physic	cian: To the best of	my knowledge, d	eath occurred at the ti	ime, date and place, an	d due to the cause(s) and manner as	stated.
the Hosp in 24 hou the Fune in 24 hou the Fune pletely fill edical	(Check only 2 Medical Examine	r: On the basis of e and manner state	examination and/o	or investigation, in my	opinion, death occurred	d at the time, date a	nd place, and due	to the cause(s)
To T with To T Cop Mos	o. Signature and title of certifier		M	29c. Licens	se number	1 1	ate signed (Month	Dey, Year)
00 30	ame and address of person who com	inleted cause a de-	ath (Item 23a)	JJ5 (01//	/	-24-	07
_ XU L	r. Glenn Mein	nger a	000 F1	2 11 1	quare Pri	ve Balti	more 1	1021237
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Registrar DHMH 17 Rev 1/2001	APR 2 8 2004	Pion.	11 April	e -				
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Physician (Medical Examiner Dorothy M. Long	3. Time of Death 11:55A M
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Terrie Vacek/Daughter-in-law 11.7 Layfield Land, Crownsville MD 21.032 20a. Method of Disposition 3 Removal from State 1 Runial 2 Cremation 3 Removal from State 4 Condition 5 Other (Specify) Mt, Carmel Cemetery 04/29/2004 Pasadena, MD	de)
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Mt, Carmel Cemetery 04/29/2004 Pasadena, MD	State
21 Signature of Funeral Society Licensee 22 Name and Address of Facility	
21. Signature of Funeral Societies 22. Name and Address of Facility Stallings Funeral Home,	P.A.
shock, or heart failure. List only one cause bryeach line.	proximate lerval Between
Physician Immediate Cause (Final disease or condition Suddling Fin	nset and Death
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icate be expended to the state of the state	
So the first poor of the first	y Year
1 Yes 2 Mo 9 Unknown 9 Unknown 9 Unknown	
	ause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause given in Part I. 1 Yes 2 1 No 3 Probably 24b. Were autopsy (i	y 4 □Unknown
To determine the second of the	findings available
1 Yes 2 New Year 1 Yes 2 Yes 2 New Year 1 Yes 2 New Year 1 Yes 2 Yes 2 New Year 1 Yes 2 Yes 2 Yes 2 New Year 1 Yes 2 Yes	
I Inpatient 2 EPVOutpatient 3 DOA 4 Nursing Home 5 U Besidence 6 Other (Specify)	
27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1	
27. Mann of Death 1 Criatural 28a. Date of Injury (Month, Day Year) 28b. Time of Death 1 Criatural 3 Suicide 3 Suicide 4 Homicide 28b. Date of Injury 4 Work? M 1 Yes 2 No 28b. Lingury 4 Work? M 1 Yes 2 No 28b. Lingury 5 Death 1 Criatural 5 Pending 1 Nonth, Day Year) 28b. Direct of Injury 28b. Time of Death 1 Pending 1 Nonth, Day Year) 28b. Lingury 4 Work? M 1 Yes 2 No 28b. Location (Street and Number or Rural Roubling, etc. (Specify)	
Duilding, etc. (Specify) City or Town, State)	oute Number,
The street of th	oute Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	d.
1 Shoulder Keday D30568 4.26.04	d. e cause(s)
30. Name and address of perso, who completed cause of death (Item 23a) (Type, Prin.)	d. e cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Prin.) 76+50400000000000000000000000000000000000	d. e cause(s)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar APR 2 8 2004	d. e cause(s)

		For State Registrar 1. Decedent's Name (First, Middle, Las	State of Maryland		tment of F			g. No. 20	0 4 3 4 3 4 3 5 1 3 1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1
Physicia /Medic Examine	al -	Daryl Handley Lev	vis, Sr.	4	b. City, Town, o	Location of Death	Month April 2	Day	Year 1:10 P
uneral irector		213-16-/968	Ou		If Under 1 Year Months Days	Parkville If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) Apr 8,		nore 9. Birthplace (State or Fo Country) MD
in result and wellist hypeles. The strain are the strain of the strain of thems 23a or 28e-f show other traumatic event, the Medical Evaridizer must be excitived at	eral Director	Usual Residence of Decedent 10a. State	re Park	own or Locat	10f. Zip Code 21234	Othica (Con	τ	g. Citizen of WI	States
an "naturel", or Item Medical Examiner	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grace) Elementary/Secondary (0-12)	Armed Forces? 1. ⊇Yes 2 □ No If Yes, Give Year or Dates: W W	1 C	Yes 2 No	ispanic Origin? (Spe n, Mexican, Puerto I Specity: ation Juring most of workir	ng 16	Specify:	
and mental rayleste. Is marked other than aumatic event, It a Me	To Be Com	12 17. Father's Name (First, Middle, Last) Edgar Reese Lewis 19a. Informant's Name/Relationship (T.	5	Car De		18. Mother's Name Mary Ha and Number or Rura	ndley		
Importent: If item 27 Is any injury or other traur		Sheila Lynne Bowe 20a. Method of Disposition 1 Burial 2 Scremation 3 1 3 4 Donation 5 Other (Specify,	ers/Daughter 20b. Place come	2217 K of Disposition of tery, cremate		Park Cir.	Bel Ai	r, MD 2	21015 lity or Town, State
any inj		21. Signatura of Funeral Service Licent Hamiltonian Service Licent Hamilton	MOOYSU	C:	717 Gree	and Fune n Pasture	s Drive	_Baltin	OS MD Approximate Interval Betwee Onset and Dea
ysicia ne bui	ical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einer Underfying Cause (Disease or injury that imitated events resulting in death) Last	Due to (or as a consequence Due to (or as a	ce of): \ \ \ \ \ ce or): \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ascu\a	er Dis	sease	-	
by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown		topic pregnancy ther (specify)			23d. Date Monti	
en signed t	ted by P	Part II. Other significant conditions co			riying cause give	n in Part I.			ute to the cause of death
S CI	Completed by	Hy pertens	ion				24a. Was an autopsy performe	pri d? de:	ere autopsy findings avair or to completion of cause ath? Yes 2 (1247)
his cer	0 B	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending investigation		Outpatient D. Time of Injury	28c. Injury Work	at 2	(Check only one) ne 5 Residence 8d. Describe how		
To the Fuheral Director:	al Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	lge, death oc	factory, office	e, date and place, a	City or Town, S	State) se(s) and mann	or Rural Route Number,
To the Fu	Medical	(Check only 2 ☐ Medicel Exami	ner: On the basis of examination and manner stated.	and/or invest	29c. License	number	d at the time, date	and place, an	Month, Day, Year)
41	-	30. Name and address of person who co	ompleted cause of death (Item 23a	a) (Type, Prir	D 580	046	A	rpr.1	54, 500

Carl Lewis unpend item#23a-b,27,28a-f, FR Ne, (831,5/13/0/eg. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02707 RJ State of Maryland / Department of Health and Mental Hygiene 1- State
Registrator NFND TTFM #14820b PER FH C831 5/04/ We the ficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year April 2004 17, 0255 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year Stimore lear If Under 24 Hrs. Greater Baltimore Medical Center Baltimore County

9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Ye **Funeral** Days Min. 1 M 2 □ F Hours 214-34-535 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Directo Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 or Items 23a Pring Lane Funeral 12. Was Dependent Ever if U.S. Armed Forces?

1 Yes 2 0 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 □ Divorced "naturel" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working than Elementa (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Importent: If item 27 is marked other tha any injury or other treumatic event, If all 2006. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ 19a. Informant's Name/Relationship (Type, Print) SCC1a 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Metro 0. 1929 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 4/30/04 -10n 22. Name and Address of Facility ature of Funeral Service License Home 21216 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Asphyxia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration of food bolus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 physician Physiclan/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 1X Yes 2 No 1 XYes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۲ 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending

death.

Certification;

To the Hospitel or Attending Physicien: Director: within 24 hours a To the Funerel [filled

2 X Accident 3 Suicide

30. Name and address of person w

investigation 6 Could not be determined

4/17/04

adult day care

found 2:20\$ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 No

subject choked on food

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1840 York Rd, Suite H, Timonium, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Scenberg MD Josha

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year)

and

Year

April 20, 2004 completed cause of death m 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State APR 2 8 2004 Registrar

4 | Homicide

(Check only one)

29a. Certifier

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND UTEM #5 PER FH C830 2/28/04 Refertificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month D4 1010 Year Joyce MCCLURKIN 22 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21TCHIE NURSING HOME BALTIMORE 5. Social Security Number LINK 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 ☐ M 2 🕱 F Hours Director 218-28-6519 MD 09 14 1933 Usual Residence of Decedent 10a. State 10c. City, Town or Location ortent: If item 27 is marked other then "neturel", or items 23e or 28e-f show injury or other treumstic event, the Mudical Examiner must be notified at 10d. Inside City Limits MD BALTIMORR 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 136 N. MONASTERY AVENUE 21229 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Specify: 13LACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE MANAGER 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JASPER BYRD BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lages 1 and 2
Lapartment of Health an Importent: If item 27 is meny injury or other any eny injury or other DONNA MCCLURKIN-FLETCHIE 15303 JOHNSTONE LANE BOWIE, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 04/27/04 BALTIMORE, MD NEW CATHEDRAL 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensia 22. Name and Address of Facility VAUGHT C. GREENE FUNERAL SERVICES an 5/5/BALTIMORE NATIONAL PIKE BALTIMORE MD 2/229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner uku Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a) onsequence of): Examiner as the burial-transi Due to (or as a consequence of): the attending physician Physiclan/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2XNo 9☐ Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NIDDW 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 certificate 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner-of Death 28b. Time of Medical Certification: Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D0032446

State Registrar

31. Date filed (Month, Day, Year)

APR 2 8 2004

D.

30. Name and address of person

QOH.

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Sparker

Jose.

iCHIE NUrsing

		Please I		ack Indelible Ink. E / Department of Hea			5.
		1 - For State Registrar	otato of marytana	Certificate of De		Reg. No. 20 (13438
Physic /Medi		1. Decedent's Name (First, Middle, Last) ANNA P	Mali	cowski	Mo	te of Death onth Day Ye	3.55 A M
Exami	ner	4a. Fecility Name (If not institution, give	treet and number)	note Man lie	ation Death	le / trade 2	head Howa
Funeral Director		5. Social Security Number 6. Sex 2/3 - 30 - 2503	VIII	hirthday) H Under 1 Year If Months Days H	Under 24 Hrs. Dat lours Will. (Mo	te of Birth (porth, Day, Year) 9.	Birthplace (State or Foreign Country)
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10 / 4	10c. City, 1	FIMORE	1 iTV		10d. Inside City Limits Yes 2 ☐ No
vith the	Director	10e. Street and Number	1	10f. Zip Code		10g. Citizen of Wha	t Country?
death v ms 23e	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban, N	nic Origin? (Specify Ye	95 or No- 14. Race - /	American Indian,
ING 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. In a hygiene. In a hygiene is the second of the hygiene is the hygiene. event, the Medical Examinat must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		pecify:	Specify:	WAITE
215-003 hin 72 hours and "natural", o	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	n ng most of working	16b. Kind of Busine	ess/Industry
d 212 filed with Hygiene. ther the	Соп	17. Father's Name (First, Middle, Last)		DINDING	Mother's Name (First	Middle, Maiden Surname)	5
Z S E P ≥	To Be	1 1 2 1	10125Ki	1	LEANORA	SZULCZ	EWSKI
Ma d 2 : th ar th ar trau		19a. Informant's Name/Relationship (Ty,	oe, Print)	19b. Mailing Address (Street and	Number or Rural Route	Number, City or Town, Sta	te, Zip Code)
altimore, mit. Pages 1 an pertment of Heal portant: If item 2 y injury or other		20a. Method of Disposition Burial 2 Cremation 3 R	com	e of Disposition (Name of etery, crematory or other place)	AFTA . ZL	20c. Location City	or Town, State
Baltimor permit. Pages Depertment of important: If it any injury or o	,	1 □ Donation 5 □ Other (Specify) 21. Signature → Funeral Service Litense	Ac	22. Name and Address of	Facility - D- G	+ DACTO.	MD.
Baffi permit. Departm Imports any inju		Athonas .	Skoule n.	SKARDA FI	4 DALT	D. 100-212	214
Physician /Medical Examiner		23a. Part1. Enter the disease or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line. Due to (or as a consequer	al vasu	lan G		Approximate interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	ice of).			U
60, be executed sician and burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	nce of):			
687 tificate ng physi as the	ledica						
.O. Box 687, the death certificate by the attending physis	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3 Ectopic pregnancy		23d. Date of Month	delivery Day Year
ਰ ਦੂ ਰੂ ਜ਼ਰੂ		Part II. Other significant conditions con	tributing to death but not resulting	ng in the underlying cause given in	n Part I. 23	le. Did tobacco use contribut	e to the cause of death? Probably 4 □Unknown
Division of Vital Records, for Attending Physician: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be do	Completed					a. Was an autopsy performed? deat	
Vital ician: Sertifica ector. p	Be	25. Was case referred to medical examiner?	lospital:		. Place of Death (Chec		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	tion: To	27. Manner Death 1 Mutural 5 Pending	1 1 patient 2 EH	3b. Time of 28c. Injury at Work?		☐ Residence 6 ☐ Other (Sescribe how injury occurred	Specify)
Division Attendent after deat Director:	Certification:	2 Accident investigation 3 Suicide 6 Coul not be 4 Homicide d mined	28e. Place of Injury - At home building, etc. (Specify)		28f. Loc	cation (Street and Number o y or Town, State)	r Rural Route Number,
Divisi To the Hospital or Attenwithin 24 hours after dealt To the Euneral Director:	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Examin	sician: To the best of my knowle her: On the basis of examination and manner stated.	edge, death occurred at the time, on and/or investigation, in my opinion	date and place, and due on, death occurred at th	e to the cause(s) and manne le time, date and place, and	r as stated. due to the cause(s)
To the within To the compl	Me	29b. Signature and titl of centrier	Las al	29c. License nu	mber — /	29d, Date signed (M	Ionth, Day, Year)
1		30. Name and address of person who co	mpleted cause of death (Item 2:	3a) (Type, Print)		12110	4
		Howard	County C	Removed 14	upite		
7 13	ate	31. Date filed (Month, Day, Year)	32. Registra s Sign yu				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	ryland / De	epartment Certificate	of H	ealth and Death	d Mental Hy	/gien	Z	13439
ı	Physic	ian	Decedent's Name (First, Middle, Las						2. Date of D		ay Year	3. Time of Death
	/Medi		Marie P.	Matthe	WS				April		5, 2004	7:00 A M
	Exami	ner	4a. Facility Name (If not institution, give	street and number)		1		Location of De	eath	4.	c. County of Deat	
_	Funeral		Casey House 5. Social Security Number 6. Se	x 7. Age	(In yrs. last birtho			ville	rs. 8 Date of Bi	rth	Montgom	
	Director			⊐м 2ДТГ	76 Yrs	Months	Days	Hours M	in. (Month, D.	ay, Year		hplace (State or Foreign untry) th Carolina
	pur .		Usual Residence of Decedent 10a, State 10b, County		100 Cit. T-					, 1	727 1101	
	Aaryla F shore	ъ			10c. City, Town o		1	o .				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28e-	Directo	Maryland Montgome	ELY		10f. Zip (Spring	3	10a C	itizen of What Co	
	h with	a D	413 E. Indian Spi	ring Dr.		1011219	209	01		_	ited Sta	•
	ems a	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	3. Was Decede	ent of His	panic Origin?	(Specify Yes or No erto Rican, etc.)		14. Race - Ame	rican Indian,
36	or It	by Fu	1 Never Married 2 X Married	1 ☐ Yes 2 💢 No If Yes, Give	0	1 Tes, speci		Specify:	erto Alcan, etc.)		Black, White Specify: W	e, etc. Thite
21215-0036	72 hours after death with the Maryland natural', or tems 23e or 28e-1 show alsal Evaninar must be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:	160 De							
15	n "na	Completed	(Specify only highest grad	de completed)	(G	ecedent's Usual live kind of work e. DO NOT use	c done du	ion iring most of v	vorking	16b. k	(ind of Business/	ndustry
212	giene giene er tha	Com	Elementary/Secondary (0-12)	College (1-4or 5+	.)	Secre	tary			Lice	ense & T	itle Comp.
pu	be file tal Hy d other	Be (17. Father's Name (First, Middle, Last)	_					ame (First, Middle	, Maidei	n Sumame)	
yla	Meni Marke	2	Jonah	Perry				Molly		L.		illiams
altimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23e or 28e-f show any injury or other traumatic event, the Medical Experiment must be notified at ance.		19a. Informant's Name/Relationship (T) William M. Matthew						Rural Route Numb			
<u>6</u>	Heall Heall tem 2	1 /	20a. Method of Disposition		20b. Place of Discemetery, of				Dr., Sil		ocation - City or	
mo	Pages ent of nt: If i		1 ☐ Burial 2 X Cremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify)		Chesapea			12171	il 27,			
altii	mit. I		21. Sign (ure que une per Service License		00382		-	-	004 Crematio		eltsvill	ie, m
Ö	Depa Impo any Ir		Justu O nota	mann					lver Spr			910
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, I sauru to immediate	a. Metas Due to (or as a	static Br consequence of):				ac or respiratory a	rrest,		Approximate Interval Between Onset and Death 6 Months
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):							
P.O. Box 6	that the death certific ed by the attending p detached for use as i	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic prec 5 □ Other (spec					23d. Date of deliving Month	rery Day Year
<u>ر</u> ر ت	res that signed to be deta	by Pi	Part II. Other significant conditions con	ntributing to death but	not resulting in the	underlying cau	nevig ea	in Part I.	23e. Did to	obacco (use contribute to	the cause of death?
Records,	w require been sig should b		Malignant Pl	<u>eural</u> Effu	sion				1 🗆 🗅	es 2	∑ No 3□Pro	bably 4 Unknown
ecc	ne faw re has bei ge 2 sho	Completed							24a. Was		24b. Were aut	opsy findings available
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Vita	cian: ertific ector,	Be	25. Was case referred to medical examiner?						eath (Check only o			
ס ר	Attending Physician: The lair death. ector: After this certificate has by the funeral director, page 2	ertification: To	27. Manner of Death 1 XNatural 5 Pending	fospital: 1 Inpatient 28a. Date of Injury (Month, Day)		of 280	: Injury a Work?	t Nursing	Home 5 Resid			Mospice
S	death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	(- At home form	M		s 2□No	Opt Leasting (6	Sa		
=	- 9 -	0	4 Homicide determined 29a. Certifier 12 Certifying Physics	building, etc.	(Specify)				City or Tow	m, State	,	
21	To the Hospital of within 24 hours af To the Funeral Discompletely filled in	edical	(Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or	ath occurred at investigation, in	the time, my opin	date and place ion, death occ	e, and due to the ourred at the time, or	date and	and manner as s place, and due to	tated. o the cause(s)
	To the To the Comp		29b. Signature and title of conflict	1/)		29c. l	icense n	umber		29d. Day	e signed (Month,	Day, Year)
			Statt	K		F	DO	5442	218	4/	25/09	+
d	7		30. Name and address of person who co				TF			11		1
	0		Charles Harrison 31. Date filed (Month, Day, Year)	M.D.; 6001		er Mill	Rd.	, Rock	ville, MI) 2	0855	
	Sta Registra	7.6	APR 2 8 200		es la	low	ء مسد	-				

David Mitchell Amend Items 20b, c. per FH, G832, U6/19/04dhb. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001 04-02850 Amend & Unpend Item #1,25a,2/ per me 631,5/20/04 fas Certificate of Death

Reg. No. RJ For A State A Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Physician April 26, David Mitchell 1148 -David Mitchell Sr /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore
If Under Vear | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 2170 Hollins Street
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) Months 1**X** M 2□ F Yrs. 217-52-6214 Director 01/26/1950 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits ty∏Yes 2 ☐ No Directo Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 2170 Hollins Street 21223 death Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) a filad within al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Apartment Upkeep 11 Maintenance Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) E. Pages 1 and 2 should be fill timent of Health and Mantal H tant: If item 27 is marked off jury or other traumatic even Melvin Mitchell Evelyn Melton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Park Wyrth Ave., Baltimore, Maryland 21218 Tetra L. Mitchell / Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Sacret Heart of Jesus 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD permit. Page Department of Important: If any injury or ance. 1 4 ☐ Donation 5 ☐ Other (Specify 05/01/2004 Landodewne, Zion Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prosician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran and Due to (or as a consequence of): Records, P.O. Box 68760; iding physician pe iclan/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy to in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) ned by the a Physi 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No 2∏ No 1 Yes Division of Vital 1 TYAS 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ¹X Yes 2 □ No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: or Attending Injury 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fillad in To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

Parding D

31. Date filed (Month, Day, Year)

29b. Signature and tithe of

32. Registrar's Signature

Rosen S. Apartis

29c. License number

30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 27, 2004

State

Registrar

nysicia	in.	1. Decedent's Name (First, Middle, L	ast)			M.	ura.	,		2. Date of De Month		Year	3. Time of Death
Medic		Esther			·					APRIL	26, 20		12:58 A
xamin	er	4a. Facility Name (If not institution, g		r)		4b. City,	Town, or	Location o		_	4c. Co	inty of Death	
1		JOHNS HOPKINS 5. Social Security Number 6.		Age (In vrs.	. last birthday)	If Under	1 Year	BALT If Under:		8. Date of Bir	th		N/A nplace (State or Fore
neral ector		218-44-5037	1□M 2∏F		76 Yrs.	Months	Days	Hours	Min.	DEC. IS	19 27	Cou	EGYP
=		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside City Lim
fled	to	MD N/A			BALT:	MORE						į	1 X Yes 2 □
event, the Madical Examiner must be notified at	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	untry?
Tan Tan	ral	250 S. PRESIDEN						2120					U.S.A.
INBLU	Funeral	11. Marital Status1 ☐ Never Married2 ☒ Married	12. Was Decede Armed Force 1 Tyes 2	s?	J.S. 13.	Was Deced If Yes, spec	dent of Hi city Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto l	cify Yes or No Rican, etc.))- 14. [Race - Amer Black, White	
EXB	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	a) 140 3:		1 ☐ Yes	2 X No	Specify:			Spe	ecity:	WHITE
lical	Completed	15. Decedent's			16a. Dece	dent's Usua kind of wo			of worki	na	16b. Kind o	f Business/Ir	ndustry
A Mac	du	Elementary/Secondary (0-12)	2 College (1-40	r 5+)	life.	DO NOT us	se retired,)	3, 1,0,7,1,1	,9	COSMI	ETOLOG	V
<u>a</u>		17. Father's Name (First, Middle, Las			BEAU	TICIA	114	18 Mothe	r'e Namo	(First, Middle,			Y
matic event, Ira M	To Be	YAAKOV	•/		ABDAI	ΙA			RIE	(1 li st, 1modie,	Waldell Sul		MASSUDA
other treumatic	ř	124 Jatorry nt's Name/Relationship	(Type, Print)				(Street a			l Route Numbe	er, City or To		
er treu			BAND		250	S. PRI	ESIDI	ENT S	TREE	T #303	- BAL	TIMORE	, MD 2120
or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□Removal from Sta		Place of Dispo cemetery, crer	sition (Nam natory or o	ne of ther place	9)	D	ate	20c. Location	on - City or T	own, State
njury	1	`4 □Donation 5 □ Other (Spec		ARL	INGTON								RE, MD
any njury		21. Signature of Funeral Service Lic	ansee Cutt	Den.						LEVINS OAD - F			INC. MD 21208
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus	ed the dea									Approximate Interval Between
ian		Immediate Cause (Final disease or condition	1	teri	al Se	PSIS							Onset and Death
ical iner		resulting in death)	Due to (or a			1 312							ONC WEE
	<u>-</u>	Sequentially list conditions,	b. Due to (or a	teri		fect	100						Ten day.
unsit	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
burial-transit		resulting in death) Last	C. Due to (or a	as a consec	quence of):								
, <u>e</u>	Ical		d										
- 52	Physician/Medical	IF FEMALE:	72a Hunn auton										
for use a	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant	2 Feta	al death 3	Ectopic pr						Date of deliv Month	ory Day Year
ached	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknown		Jean 3L	J Other (Sp	<u>өспу)</u>						
0	by Pr	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying c	ause give	n in Part I,		23e. Did to	obacco use c	ontribute to t	the cause of death?
should b										101	Yes 2□No	3 ☐ Prol	bably 4 Unkno
CI	Completed									24a. Was		b. Were auto	opsy findings availa
pad	Con									perfo	rmed? 2 No	death? 1 ☐ Yes	2□ No
	Be	25. Was case referred to medical examiner?	Hospital:		1		04-		of Death	(Check only o	nne)		
g g	ပ	1 Yes 2 No 27. Manner of Death	1 X Inpa		ER/Outpatien			4 LI Nui		ne 5 ☐ Resid !8d. Describe f			fy)
funer	tl ol	1 Natural 5 Pending 2 Accident investigati	28a. Date of Ir (Month, L	Day Year)	Injury	М	8c. Injury Work 1 □ Y	? ′es 2.⊡N		.00. 00001100 1	iow injury co	Juli 90	
by the	Certification;	3 ☐ Suicide 6 ☐ Could not determine	be 28e. Place of	njury - At h	iome, farm, str	eet, factory	, office		2			mber or Rura	al Route Number,
ui þe	Cert	4 - Homicide	bullding,	etc. (Speci	19)					City or Tow	vn, State)		
completely filled	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	hysician: To the bearing: On the basis and manner	of examina	owledge, death ation and/or in	occurred estigation,	at the tim in my op	e, date and inion, deat	d place, a h occurre	nd due to the o	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
completely filled in by the	Me	29b. Signature and title of certifier				290	License	number			29d. Date sig	ned (Month,	Day, Year)
0		> Mustak	MD				RE.	5-0	00		April	26,	2004
		1110101 60111	1-11/								-		
		30. Name and address of person wh Lauren Marie Aver 31. Date filed Mouth, Bay, Your	completed cause o	f death (Ite	m 23a) (Type ,	Print)							

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F	lealth an Death		iene g. No. 20	04	134	142
	Dhysia	ion	Decedent's Name (First, Middle, Last)					2. Date of Deat	h		3. Time of	Death
	Physic /Med		Frank Michael Nov	esl, III				April	24,	2004	7:43	Ам
	Exami	ner	4a. Facility Name (If not institution, give str 116 Bladen Road	eet and number)		4b. City, Town, o		eath	4c. Count Ba	y of Death ltimo	re	
	Funeral Director		210-13-0307	7. Ag	e (In yrs. last birthday, 30 Yrs.	If Under 1 Year Months Days	Hours M	lin. (Month. Day.	^{Year)} 8,1974	Coun	ace (State of try) Land	r Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10	Od. Inside Cit	ty Limits
	the Marylar 28a-f show	to	Maryland Baltimore		Essex						1 🗆 Yes	
	h the	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of	What Coun	trv?	
	th wit		116 Bladen Road			21221			U.S.A.			
	r dea	Funeral	11. Marital Status	. Was Decedent Armed Forces?		Was Decedent of H	lispanic Origin?	(Specify Yes or No-		ce - America		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene, itam 27 is marked othar than "natural", or Itams 23a or 28a-1 show othar traumatic avent, the Marical Experiment must be maritied as	b	1XXSever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2XX If Yes, Give Year or Dates:	No	1 ☐ Yes 2504No	Specify:	John Moan, Blc.)	Specif	ck, White, e		
5	natu	ete	15. Decedent's Educa (Specify only highest grade of	tion completed)	(Give	dent's Usual Occup	during most of	working	16b. Kind of B	usiness/Ind	ustry	
12	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retired ete Finis	1)		Const	auctic	nn.	
d 2	filled Hygir othar		17. Father's Name (First, Middle, Last)		Conce	ccc i iiii a		Name (First, Middle, M)I I	
lan	ould be filed withi Mental Hygiene. arked othar than atic avant, the M	To Be	Frank Michael Noves	l, Jr.				Jean Groft		110)		
ary	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship (Type	, Print)	19b. Maili	ng Address (Street a	and Number or	Rural Route Number,	City or Town,	State, Zip	Code)	
	Health Health tam 27 i		Frank M. Novesl, Jr	. (Fathe				altimore, M				
ore	of He of He If itan		20a. Method of Disposition 1 ☐ Burial 2XCremation 3 ☐ Ren	noval from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other plac	ea)	Date 2	Oc. Location -	City or Tov	vn, State	
Ë	Pag tment tant: jury c		`4 □Donation 5 □Other (Specify)		Bayview C	rematory,	Inc. 04	4/29/2004 I	Baltimo	ore, M	arylaı	nd
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar	1	21. Signatura of Funeral Strvice Licensee		22	2. Name and Addres Br 1407 Old	ss of Facility UZdzins Easterr	ski Funera 1 Avenue, I	l Home,	P.A.	and 2	1 2 2 1
			23a. Part1 Priter the disease, or complica shock, or heart failure. List only one	tions that caused	the death. Do not ent	er the mode of dying	g, such as card	liac or respiratory arre	st,		Approximate Interval Betw	
	Physician		Imme I te Cause (Final	INT	RAGRAI	GUN	SHOT	WOUND		11	Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):			0007142				
Н	- Zaminier	_	Sequentially list conditions, b.	Due to Jones	P.							
	nsit	nin	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a	a consequence of:							
	cate be executed oblysician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	a consequence of):							
8760,	le be ysicia e bur	dlcal	d. =									
9		led										
Вох	death certifica e attending ph id for use as t	an/h	230. Was decedent pregnant	If yes, outcome of		Ectopic pregnancy				e of deliver	/	
o.	the dea by the at ached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown		Other (specify)			Moi	nth [Day Ye	ear
σ.			Part II. Other significant conditions contri	buting to death bu	it not resulting in the ur	derhing cause au	on in Part I	22a Did toba	acco use conti	ribusta sa sha		-452
ds,	ng ign be	d by	•		it not rooming in the di	identying cause give	HINIT OLILI.	1 ☐ Yes	***	3 Probal		
Records	S □ S	Completed						24a. Was an	TIAL			
Re	The law ate has b page 2 sl	dmo						- autopsy	P	vere autops prior to com leath?	sy findings av	valiable use of
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical				26 Place of O	eath (Check only one	□ No 1		□ No	
	99	To B	examiner?	pital: 1 🗀 Inpatier	nt 2 ER/Outpatien	t 3□ DOA Othe	P.	Home 5 Residen		er (Specify)	at so	cene
	ng Ph ter th neral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Time of		at	28d. Describe how	/ injury occurr	ed		
Sio	Attanding r death. actor: After oy the fune	catle	2 Accident investigation	OUND 4/24	1 778	A M 1□Y	h	SUBJEC	7 SHU	TSEL	F	
ā		Certification;	3 Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Inju building, etc.	ry - It home, farm, stre . (Specify) A LL	eet, factory, office		28f. Location (Stre City or Town,	et and Numbe State) 16	BLA	DEN R	er,
	To tha Hospital or within 24 hours afte within 24 hours afte To the Funaral Discompletely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner	an: To the best o On the basis of and manner stat	examination and/or inv	occurred at the time estigation, in my op	e, date and pla inion, death oc	ce, and due to the cau curred at the time, dat	ise(s) and mai e and place, a	nner as stat and due to the	ed. ne cause(s)	
	To tha within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed	(Month, Da	iy, Year)	
	^		\rightarrow $V\Lambda$	Vin	~	0	.C.M.E.	. A	April 2	5, 20	04	
	/h		30. Name and address of person who comp	leted cause of de	eath (Item 23a) (Type, I	Print)						
			MARY G. R	IPPLES	~ 111	Penn Stre	et, Bal	timore, Ma	rvland	_2120	1	
	Sta Registr	. •	31. Date filod (Month, Day, Near) APR 2 8 2004		r's Signature	Som V.		- ,	-1		_	

			1 - For State Registrar	State of Marylar		rtment of H			giene Reg. No. 201	04 1344;
,	Physici /Medic Examir	al	4a. Facility Name (If not institution, give	A EVERS OSSMAN			Location of Death	2. Date of Dea Month April	Day Ye 24, 2004 4c. County of I	
	Funeral Director		BRIGHTON GARDENS 5. Social Security Number 6. S 219-30-4512 Usual Residence of Decedent		last birthday)	If Under 1 Year Months Days	altimore If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De)	h v, Yeer) 9.	ore County Birthplace (Stete or Foreign Country) Maryland
d 21215-0036 filed within 72 hours after death with the Maryland	"natural", or Itams 23a or 28a edical Examiner must be noti	e Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor 10e. Street and Number 6451 North Charl 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grave Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	e County es Street, #24 12. Was Decedent Ever in U Armed Forces? 1 Yes Give X Year or Dates:	16a. Deced	imore 10f. Zip Code 10f. Zip Code Vas Decedent of H Yes, specify Cuba Gress 257 No ent's Usual Occupi	luring most of work)	ecify Yes or No- Rican, etc.)	10g. Citizen of Wha US 14. Race - / Black, V Specify: 16b. Kind of Busine	10d. Inside City Limits 1 □ Yes 2 No t Country? A American Indian, White
Baltimore, Maryland	Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other then eny injury or other traumatic event, the Mone.	To Be	James 19a. Informant's Name/Relationship (1) Gay L. Rudow (Dau 20a. Method of Disposition 1 Burial 2 Commation 3 Donation 5 Other (Specify 21. Signature of Fune all Service Desn Martin D. Law 23a. Part Lenter the disease, or compare specific properly	phter) Removal from State Gre	14 Dys	Son-Dan (ition (Name of atory or other place of Cremat	Mary E	11en Sclar Route Number isterstropate	nermeyer r, City or Town, State Dum, Mary 20c. Location - City Baltimore	land 21136 or Town, Stata
executed (I)	hysician and Medical (aminertransit	Icai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the shock of the sh	b	quence of):	I the mode of dying	g, such as cardiac of	or respiratory arr	est.	d 21212 Approximate Interval Between Onset and Death
of Vital Records, P.O. Box 68760	signed by the attending phid be detached for use as the	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	il déath 3□i leath 5□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Records, F	as been 2 shou	Completed by F	Part II. Other significant conditions co	entributing to death but not res	ulting in the un	derlying cause give	n in Part I.	1 Ye	n 24b. Were prior death	
ision	affer death. Director: Affer this certificate hat in by the funeral director, page	Certification: To Be C	27. Mnn r of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 \(\text{Y}	at ?	n (Check only on the 5 Reside 28d. Describe ho	ence ÉU Oner (Sow injury occurred	'es 2□ No ipecify) A L Rural Route Number,
Division To the Hospital or Attending	within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Medical Certi	4 Homicide determined 29a. Certifier (Check only one) 29 Medical Exam	building, etc. (Specifications of the best of my known of the basis of examina and manner stated.	y) wledge, death	occurred at the tim	e date and place	City or Town	1, State)	as stated
To th	within within comp	Me	29b. Signature and title of certifier Muld 30. Name and address of person who certifier	1.7		rint)	1433	1	9d. Date signed (MC PRAL 24,	2004
	Sta Registr		Mel Daly, M.D., 31. Date filed (Month, Day, Year) APF	OZ. Hogistiai s Oigila		treet, Su		Towson,	Maryland	1–21204

	1	For State Registrar	State of		Department (of Health and	d Mental Hy	giene 200	4 13666
Physicia	n	1. Decedent's Name (First, Middle,	OSTAN	· · · · · · · · · · · · · · · · · · ·			2. Date of De Month		3. Time of Death
/Medica Examine	r	Montgomeny 6	give street and numb	HaspitaL	OLA	wn, or Location of De JEY, Mai	eyland.	4c. County of De	MERY
Funeral Director		5. Social Security Number 2/2-1/1-0193 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	Age (In yrs. last birt	Yrs. If Under 1 Months C		fin. B. Date of Bi	ay, Year	inthplace (State or Foreign Sountry) NRAW, TRAN
Maryland -f ehow		10a. State 10b. County	orth Hampto	N EAST					10d. Inside City Limits 1 √Yes 2 □ No
3a or 28a	Funeral Directo	10e. Street and Number 135 NeLson F	tre.,		10f. Zip Co	8040		10g. Citizen of What C	States
72 hours after death with the Maryland 72 hours after death with the Maryland 72 hours 23a or 28a-f show 51cal Examilrar match to colified at	by Funera	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force	95? No		nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No Juerto Rican, etc.)	Specify;	
- c	Completed	(Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4	05.54\	Decedent's Usual C (Give kind of work of life. DO NOT use L OUSE WIT	done during most of i retired)	working	16b. Kind of Busines:	s/Industry
should be filed within and Mental Hygiene. marked other than amatic event, it a M	lo Be Co	17. Father's Name (First, Middle, L	rgi Ost			18. Mother's N	Name (First, Middle	n, Maiden Sumame) Adat	
es 1 and 2 sho of Health and 1 ft fem 27 fe my or other traum		19a. Informant's Name/Relationsh OUSSET 30a. Method of Disposition 1 ABurial 2 □ Cremation	p (Type, Print) R.S.h.A.POI 3 □Removal from Sta	IR 20b Popp	35 Nelso	n Huenue Cometeni	EAST	on, tannsy	zip code). 18040 lvani a IPS/MIH Road Md 20848
permit. Pag Department Important: I eny injury o	-	4 Donation 5 Other (Sp. 21. Signature of Funeral Service)	ecify)	April	24, 200 22. Name and A	Address of Facility	H24/04 Pape Fune	RAL Homes.	Md 20848 PH 19, Md 20904
Physician		23a. Pent. Ent. the disease, or o shock, or heart failure. List o Immediate Cause (Finat disease or condition resulting in death)	complications that ceu inly one cause on eac a.	sed the death. Do not he line.	not enter the mode of	of dying, such as card	diac or respiratory a	rrest,	Approximate Interval Between Onset and Dean
/Medical pe executed itician and purial-transit	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence of	5hoc Sella	K.		74.5	2 days
et e	Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death	3 □Ectopic pregi 5 □ Other (speci			23d. Date of de Month	olivery Day Year
equires that	2	Par II. Other significant condition	es contributing to deat	h but not cosulting in	the underlying cause	se given in Part I. Pletus	23e. Did t	obacco use contribute t Yes 2 No 3 □ P	o the cause of death?
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 st	Completed	Hypertens/8	<u>n</u>				1 Tes	prior to death? 20 No 1 Yes	utopsy findings available completion of cause of
hyeiciai his certii il directo	0	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital:	atrent 2 ER/Out	tpatient 3 DOA	Other	Death (Check only of Home 5 Resident)	one) dence 6 □Other (Spe	əcify)
ending Peath.	Certification:	27 Manner of Seath 1 Natural 5 ☐ Pending 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could no	ation		ime of 28c.	Injury at Work? 1 Tyes 2 No	28d. Describe	how injury occurred	
igel or Att		4 Homicide determin	ned 286. Place of building.	Injury - At home, far etc. (Specify)			City or To		
the Houp in 24 hou the Fune	edical	(Check only one) Medical E	Physician: To the be xaminer: On the basi and manner	s of examination and	, death occurred at t dor investigation, in	he time, date and pla my opinion, death or	ace, and due to the courred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
with To Toom	2	250 Signature and fittle of ceptifier	Um.		29c. L	1908		APRIZA	th, Day, Year) 2004
2		Dowid Mag	no completed cause of	18711 PRIN	Type, Print)	Deive	Olney	maglan	l 20855
State Registra	-	31. Date filed (Month, Day, Yead) APR 2 8 20	32 Reg	istrar's Signature	Spark	2	1	,	

		1 - For State Registrar	State of Marylan	d / Depa		ealth and Men Death	tal Hygier		
Physic /Medi	cal	1. Decedent's Name (First, Middle, Las	L Park		4. O's T	c ^A		Day Yeer 4 2004	
Exami	ner	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Baltir	nore		4c. County of Death Not App	
Funeral Director		213-40-7491	ex ☐ M 2점 F 7. Age (In yrs. 60	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min. Oct	pate of Birth Month, Day Ober 3,	9. Birtl Co Man	hplace (State or Foreign untry) cyland
yland now		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
Ba-f ek	ector	Maryland Not App	licable B	altimo					1 XYes 2 No
3e or 2	ai Dir	10e. Street and Number 1364 Washington B	oulevard		10f. Zip Code 21230		1 -	Citizen of What Co Jnited St	-
should be filed within 72 hours after death with the Maryland not Mental Hygiene. In marked other then "natural", or items 23e or 28e-f ehow unaftic event, the Marical Exemire mark the routiled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Specify n, Mexican, Puerto Ricar Specify:	Yes or No- n, etc.)	14. Race - Ame Bleck, White Specify:	
72 hou	eted	15. Decedent's Ec (Specify only highest gra		16a. Dece	dent's Usual Occupa	tion uring most of working	16b.	. Kind of Business/I	industry
within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT</i> use <i>retired)</i> ekeeper		Do	omestic W	orker
uld be filed Aental Hygi rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Unobtainable				18. Mother's Name (Firs Eva Barnes		len Sumame)	
and 2 shot alth and A		19a. Informant's Name/Relationship (1) James Edward Par				nd Number or Rural Roo n Boulevard			Tip Code) ryland 21230
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exporter must be notified at ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 3 Other (Specify 21. Signature of Emeral Service Linear	Removal from State Lou	emetery, crei		ny April 28, sof Facility ral Ho	2004 Ba		Maryland
Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		h. Do not en	ter the mode of dying		piratory arrest,		Approximate Interval Between Onset and Death
sate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	c. Due to (or as a conseq d.						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli	very Day Year
w requires that been signed by should be deta	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause give	n in Part I.			the cause of death?
The law recte has been age 2 shou	Completed	Lung	Cancer				24a. Was an autopsy performed?	prior to c death?	topsy findings available completion of cause of
sian: T	Bec	25. Was case referred to medical examiner?				26. Place of Death (Chi		10 103	20110
Physic rthis or ral dire	. To	1 Yes 2 □ No 27. Manner of Death	Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2	ER/Outpatier		4 Nursing Home	5 Residence		ify)
Attending or death.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	Work M 1 □ Y	es 2 No			
s after d	Certif	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	reet, factory, office	28f. L	ocation (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	edical (ysician: To the best of my kno niner: On the basis of examina and manner stated.						
To the within	W	29b. Signature and title of certifier	EMD.		29c. License	number - 4947	1	Date signed (Month)	1
1		30. Name and address of person who Katherine Gr	undmann	225	Print) Greene	St Baltin	more	HO 21	201
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	K)				

			1 - For Stata Registrar	State of	Marylar	nd / Dep <i>Ce</i>	artment of H	lealth a Death	and Mental Hy	giene Reg. No. 2		13446
П	Physici	an	Decedent's Name (First, Middle,	Last)					2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medi		LEROY		NEST	P	USEY		April	26,	2004	12:40 A M
	Examir	er	4a. Facility Name (If not institution,		oer)		4b. City, Town, or		f Death	4c. Co	unty of Death	
			3249 Lawsonia F 5. Social Security Number		Age (In vrs	last birthday	Crisf	If Under:	24 Hrs. 8. Date of Birt	h	Some	
12	Funeral Director		218-20-4924 Usual Residence of Decedent	1 ½ M 2□ F		79 Yrs.	Months Days	Hours	Min. (Month, Da April 2	v. Year)	25 Mary	place (State or Foreign ntry) land
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	10a. State 10b. County Maryland Some 10e. Street and Number 3249 Lawsonia	erset Road	10c. Ci	ty, Town or L	Crisf	ield 21817			of What Cour	0d. Inside City Limits 1 ☐ Yes 2 ☑ No htty?
21215-0036	ours after dea rel', or items Examiner m	by Funer	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Vac Give	es? □NoWOĽ	rld	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2XXNo	ispanic Origin, Mexican Specify:	nin? (Specify Yes or No., Puerto Rican, etc.)		Race Amend Black, White, ecify: Wh	
20	72 hg	etec	15. Decedent's (Specify only highest				dent's Usual Occupa		of working	16b. Kind	of Business/Ind	dustry
121	within ne. han *	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use retired)	G WOKKING		ed Sta	
io D	filed with Hygiene. other than		12 17. Father's Name (First, Middle, Li	ast)		1	Postal Wo		r's Name (First, Middle,		al Ser	vice
an	ld be ental ked o	To Be	Leroy Harvey Pu						e Marshall	Maldell Sul	name)	
Maryland	2 should be filed v and Mental Hygie is marked other t raumatic event, In	-	19a. Informant's Name/Relationshi			19b. Maili			r or Rural Route Numbe	r, City or To	wn, State, Zip	Code)
Š	1 and 2 Health a tem 27 is		Gertrude S. Puse	y (Wife)		3249	Lawsonia	Road	- P.O. Box	666 -	Crisf	ield, MD218
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 • 4 □ Donation 5 □ Other (Spe		ate	cemetery, crei	sition (Name of matory or other place Memorial Pa		Date ril 28, 2004 (on - City or To	
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service Li	Biods/a		11/1 1	Name and Address Radshaw &	s of Facility Sons	Funeral Horeet - Crist	me		***
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that cau hly one cause on eac aa	sed the deat h line.	th. Do not ent	er the mode of dying	g, such as o	cardiac or respiratory and	rest,	-Mary I	Approximate Interval Between Onset and Death
38760,	icate be executed physicien and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiated events resulting in death) Last	c.	as a conseq							
P.O. Box 6	The law requires that the death certifica te has been signed by the attending pt page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2∏Feta it at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ry Day Year
ري. ص	s that ned b e deta	by Pi	Part II. Other significant condition	s contributing to deal	h but not res	ulting in the u	nderlying cause give	n in Part I.	23a. Did to	bacco use c	ontribute to th	e cause of death?
ğ	w require been sig should b	edt		ASCVD					15XY	es 2□No	o 3 🗆 Proba	ably 4 Unknown
		Completed							24a. Was a autop: perfor 1 ☐ Yes	Sy	prior to con death?	osy findings available inpletion of cause of 2 No
Zit3	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			Otho		of Death (Check only or			
ō		- T	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time of		4 L Nur	sing Home 5 S eside)
o	ding F th: After funera	tlon	1 Vatural 5 Pending 2 Accident Investiga	(Month,	Day Year)	Injury	Work	? ′es 2 ⊡ N		ow injury oc	curred	
Divisi	afte Dir	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of	Injury - At ho etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (S. City or Town	treet and Nu n, State)	imber or Rural	Route Number,
	• Hospital or 124 hours afte • Funeral Dirk letely filled in I	edicai C	29a. Certifier Certifying (Check only one) Certifying	Physician: To the becaminer: On the basi and manner	s of examina	wledge, death tion and/or inv	n occurred at the tim restigation, in my op	e, date and inion, death	place, and due to the conoccurred at the time, d	ause(s) and ate and plac	manner as sta ce, and due to	ated. the cause(s)
	To the within 2. To the I complete	Me	29b. Signature and title of certifier				29c. License	number	2	9d. Date sig	ned (Month, L	Day, Year)
					4	9		187	98	April	26, 20	004
	O		30. Name and address of person will Vijay Karum	bunathan,	M.D.	- 201		way -	Crisfield,	Mary.	land 21	1817
D.	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signa	ture	Ma			_		

Physician /Medical Examiner	1. Decedent's Name (First, Middle,	7 IIA III 0000 2/20/	/04 J∯ertificate o		I Hygiene Reg. No. 20	04 1341
	4a. Facility Name (If not institution, s	LORRAIN	VE POFFIN	2. Date	of Death oth Day PRIL 20, 20	3. Time of Death
Funeral Director	5. Social Security Number 215-16-7895 Usual Residence of Decedent	ARS Sex 1 M 280 F 7. Age (In yrs.	last birthday) If Under 1 Yes Months Day		nth, Day, Year)	9. Birthplace (State or Fore Country)
72 hours after death with the Maryland natural; or Items 23e or 28e-f ahow acel Exandrier court be ricillised at etch by Funeral Director	10a. State 10b. County MARYLAND BALTI 10e. Street and Number	MORE PE	y, Town or Location SRRY HALL 101. Zip Code TB 212	26	10g. Citizen of Wi	10d. Inside City Lim 1 ☐ Yes 2 ☑ nat Country?
s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. If Health and Mental Hygiene is the first state of terms 23a or 28a-f ahou other traumatic event, the Medical Examinational Durinified at To Be Completed by Funeral Director	7940 BELRI 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces?		f Hispanic Origin? (Specify Yesuban, Mexican, Puerto Rican, elo Specify:	s or No- tic.) 14. Race Black Specify:	- American Indian, White, etc.
filed within 72 ho Hygiene. wither than "natura int, the Medical e Completed	15. Decedent's (Specify only highest : Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	ne during most of working red)	16b. Kind of Bus	1
nd 2 should be filed within and Mental Hygiene. 27 Is marked other than traumatic event, the Mr. To Be Comp	17. Father's Name (First, Middle, La	FFI NBERGER	19b. Mailing Address (Stre	18. Mother's Name (First, I	A BOWE	RS
tment of tant: If tant: If ijury or	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service Lie	□Removal from State	Place of Disposition (Name of emetery, crematory or other of the control of the c	ATR APRIL 27, 20	of Forest H	ity or Town, State
Permit Depart Import any inj	23a. Part1. Enter the disease, groc shock, or heart failure. List or Immediate Cause (Final	4 sceptry	8800 H	ARFORD RD	CHAPEL OF I	E MD 212 Approximate Interval Between Onset and Death
law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit anipper and physician/Medical Examiner	disease or condition resulting in death) Saquentially fish conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of):	SCULAR DISEASE		
detached for use as the Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 Ectopic pregnar	ncy	23d. Date Monti	
been signed b should be deta	Part II. Other significant conditions	s contributing to death but not res	ulting in the underlying cause (given in Part I. 23e	. Did tobacco use contrib 1 ☐ Yes 2 ☐ No 3	
page				10	autopsy priperformed? de Yes 2 No 1 L	ere autopsy findings avail or to completion of cause ath?] Yes 2 \(\) No
After th funeral	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury 28c. In	26. Place of Death (Check) Other: 4 Nursing Home 5 ury at 28d. Des ork? Yes 2 No		
r Attencer death rector. by the tifficat	3 ☐ Suicide 6 ☐ Could not determine	building, etc. (Specify		City	ition (Street and Number or Town, State)	
ral Dire	29a. Certifier 17 Certifying	Physician: To the best of my kno	wiedge, death occurred at the tion and/or investigation, in my	time, date and place, and due opinion, death occurred at the	to the cause(s) and manr time, date and place, an	ner as stated.
I o the hospital of Attent within 24 hours after deall To the Funeral Director: completely filled in by the Medical Certifical	(Check only one) 29b. Signature and title of certifier	and manner stated.		nse number	29d. Date signed (

DHMH 17 Rev 1/2001

8:35 а.ш.

APRIL 26, 2004

LOIS POFFINBERGER

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2 0 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:45AM 4a. Facility Name (If not institution, give street and number) 2004 /Medical 4c. County of Death Examiner 4b. City. Town, or Location of Death BALTIMORE Conter Ichrist Towson
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months Hours 219-28-318 70 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits BALTIMORE PARKVILLE 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Second 2706 21234. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H Ptak trank DUIS chane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl nent of Health an-ant: If itam 27 is r ury or othar traur 2706 Second Ave. BACTIMORE MD 2123 Y
Date 20c. Location - City or Town, State wite Jo Ann 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page Department of Important: If any injury or Parkingod Cemotery 14-28-04 Harkville, MD `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BALTIMORE, MD 21234. 21. Signature of Funeral Service Licensee Yellolke EVANS FUNERALCHAPEL 8800 HARFORD RD 23a. Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pinntary Physician Secondary weeks /Medical Due to (or is a consequence of): **Examiner** ASDINATION f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner end-stage Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 No her (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 24 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Balts. Md 21204 . A. Kiloy 6BMC

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 2 8 2004

32. Registrar's Signature

			Please T	ype or Print								_
			1 State	State of Ma	ryland / L	Departmo Certifica	ent of h	lealth and	Mental Hy		G U U	4 13450
			Registrar Decedent's Name (First, Middle, Last)			Oertino	ale UI	Dealli	2. Date of D			3. Time of Death
	Physici /Medio		EDWARD	J. PI	ETRUS	ZKA			April	24,	2004	8:45 A.M
and the second	Examir		4a. Facility Name (If not institution, give s					r Location of Deat			County of De	
			Johns Hopkins B 5. Social Security Number 6. Sex		led. C		altin		8. Date of Bi	eth.	n/a	interior (Canada de Francisco
1	Funeral Director			M 2□F		Yrs. Monti		Hours Min.	(Month, D	ey, Y <i>e</i> er)	926 M	rthplace (State or Foreign Country) arvland
	DI &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location			gan. z	-0 9 1	720 110	
	Maryla f eho	or	Md. Baltim		•		1					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith with the Marylan 23s or 28e-f ehow ust be natilised at	lrect	10e. Street and Number	ore		Eastwo	Zip Code			10g. Citi	zen of What C	country?
	23a o	Funeral Director	7239 Conley Str	eet			21	224			USA	
	iteme	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 XYes 2 No		13. Was De If Yes, s	cedent of F specify Cubi	lispanic Origin? (S an, Mexican, Puer	Specify Yes or Note Rican, etc.))-	 Race - Am Black, Wh 	
030	urs af	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	,	1 🔀 Yes	s 2 No	Specify:			Specify: W	nite
9500-61212	iled within 72 hours after death with the Maryland Hygione. Whet than "natural", or items 23s or 28s-f show ont, the Madical Examiner must be natilised at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	Decedent's U (Give kind of	work done	during most of wo	rking	16b. Kir	nd of Busines	s/Industry
2	within ene. then	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ipe Fi		•		F.7		D1
ם מ		e Cc	17. Father's Name (First, Middle, Last)		1 4	rpe ri	ıccer	18. Mother's Nar	me (First, Middle			Electric
) la	should be ind Mental marked o umatic eve	To Be	Joseph Pietrus	zka				Eva S	Skrucha	l		
= (0 = 0	2 S	19a. Informant's Name/Relationship (Type Mary Pietruszka		19b.	Mailing Addr	ess (Street	and Number or Ru Street				Zip Code) 21224
	ss 1 and of Health item 27 other to	7 80	20a. Method of Disposition	(W11C)		Disposition (f y, crematory of			Date		cation - City o	aryland Town, Stete
Baltimore,	m 0		1 🔀 Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	moval from State		y, crematory o Stanis			28/04		,	e, Maryland
<u> </u>	permit. Page Department of Important: If any injury of once.	ŀ	21. Signature of Funeral Service License	• //		22. Name	and Addre	ss of FacilitKac	zorows	ki I	Funera	1 Home, PA
13	# 4 5 5 8		Told fredor	7							imore,	Md. 21222
	5	ř.	23a. Pert1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line	ne death. Do r	not enter the m	node of dylin	ig, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death 3 MONTHS
	hysician /Medical		disease or condition resulting in death)	Lung C. Due to (or as a		of):						3 months
E	Examiner		Someonially list conditions				Hear	t Disea	se			10 years
7	pe d	iner	Sequentially liet on diffure if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Renal (,	•					E
1	be executed sician and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a								5 years
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20	death certificate e attending physi d for use as the k	Physician/Medic	IF FEMALÉ:								-	
XOD .	eath c attend for us	cian	in the past 12 months?	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir	Fetal death	3 ☐Ectopic		,		2	3d. Date of de Month	livery Day Year
)	y the	hysi	1 Yes 2 No 9 Unknown	9□ Unknown	0, 304	3 - 0 - 0 - 0	(Specify)					
S.	requires that the deceed signed by the a nould be detached for	by P	Part II. Other significant conditions cont	ributing to death but	not resulting in	the underlying	g cause giv	en in Part I.				o the cause of death?
ecords	nor non		Diabetes, Hyper Atrial Fibrilla		, card	10myo	path	<u>y, </u>	1 🗆	Yes 2 []No 3∏P	robably MUNknown
Hec	I ne taw ate has b page 2 sl	ompieted	ACTIAL FIDELLIA	ition					24a. Was auto		24b. Were a prior to death?	utopsy findings available completion of cause of
	en: In	e Co	25. Was case referred to medical					26. Place of Dea	1□ Yes	2 No	1 ☐ Yes	2 No
9	Pnysicien: The law this certificate has trail director, page 2 s	To B	examiner?	ospital: 1 🔀 Inpatient	2 🗆 ER/Out	patient 3	DOA Oth		ome 5 Resi		☐Other (Spe	ocify)
= {	ng P	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. T	ijury	28c. Injun Worl	at k?	28d. Describe			
DIVISION	or Attending after death. Director: After I in by the funer	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	/ - At home far	M street fact		Yes 2 □ No	29f Location /	Stroot and	(Alumbos os O	ural Route Number,
	a after I Dire d in by	ertii	4 Homicide determined	building, etc.	(Specify)	m, street, lact	lory, office		City or Tol			urai noute Number,
	I o the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical C	29a. Certifier 1 Certifying Physi (Check only one)	ician: To the best of er: On the basis of er and manner state	xamination and	death occurre	ed at the tin	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a	and manner a	s stated. to the cause(s)
1	Nithin :	Mec	29b. Signature and title of certifier	and mariner state	d.		29c. Licensi				signed (Mont	
, ,	> F 0		I Vul R (She, mi			RI	ES-000		Apr	il 24	, 2004
	10		30. Name and address of person who cor Valeriani R. Be	npleted cause of dea	th (Item 23a) (Type, Print)	enue	Ra1+4+	more, N			,
۳	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's		-11 AV		_	nore, r	IU Z	1224	
	Registr	ar	APR 2	2 8 20 4	Agrany ,	A CO	board	2				

Р			1- For Amend & Unpend Item #1,23a,pt.11,27,28a f per me (331 5/6/04) Registrar Certificate of Death	Mental Hyg tas	giene Reg. No. 2004	13451
	Physic	ian	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medi		Allen Parker	APRIL		9:05a [™]
	Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dear 2688 DULANEY STREET BALTIMORE CITY	th	4c. County of Deat	h 1
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	h 9 Birt	hplace (State, or Foreign,
12	Director		217-94-5495 1XM 20F 34 Yrs. Months Days Hours Min.	Month, Day	Year 19	ar uland
3 9	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			
	f sho	5	Man I I N/A Parti and an			10d. Inside City Limits 1 Yes 2 No
	1 28e-	Director	10e. Street and Number 10f. Zip Code	1.	10g. Citizen of What Co	/.
	23e or	ai D	2688 Dulany St. 21223		1151	7
	ems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ame Black, White	
36	s afte	by Fu	1 Nover Married 2 Married 1 □ Yes 2 No 1 □ Yes 2 No Specify:	to mount, etc.)	Specify:	j, etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23e or 28e-f show ont, the Medical Exam her must be modified at		3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/	ack
215	hin 72 e. en "ne Medi	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired) (Give kind of work done during most of wo life. DO NOT use retired)	rking	Ob. Kind of Business:	midustry
21	ed wit	Com	8 O Laborer		Private	Companies
and	s 1 and 2 should be filed within 72 hours after death with the Maryla Heath and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28e-f ethor other treumatic event, I'ra Medical Exarts bet must be sufficied at	Be		me (First, Middle, I	Maiden Sumame)	Ų.
Maryland	should be nd Mental marked c	2	19a. Informant's Name/Relationship (Type, Print) SiSter) 19b. Mailing Address (Street and Number or Ro	Ab	rams	
Ma	and 2 s ealth an n 27 is		19a. Informant's Name/Relationship (Type, Print) Sister) 19b. Mailing Address (Street and Number or Re	AVO T	City or rown, State, 2	1 2120E
ē,	ss 1 and 2 of Health litem 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	Town, State
Ē	Page: nent o ant: If ury or		1 MaBurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) 1 MaBurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	8/2004	Arhidu	< Md
Baltimore,	permit. Pages Department of H Importent: If ite any injury or ot		21. Signature of Funeral Servi / Licensee 22. Name and Address of Facility	Funer	of Home	SHIVE.
	205 20		Joseph & Kuss 2925 W. North A	ve. Ba	Ito. Md. 5	21216
_			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart fature. List only one cause on each line.	or respiratory arm	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Ethanol and Doxenin Intoxication			0.1001 4112 53411
	Examiner		Due to (or as a consequence of):			
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			
	ecuter and trans	Examiner	that initiated events c			
8760,	icate be executed physician and s the burial-transit	ai E	Due to (or as a consequence of):			
687	phy:	edicai	d			
Вох	eath certifi attending for use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	/ery
	e death	Physician/M	in the past 12 months? 1 Yes 2 No 1 Ves 2 No 1 Ves 2 No		Month	Day Year
P.0	that the de ned by the a detached t	Phy	9 Li Onknown			
ds,	9 <u>15</u> 9	l by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiomegaly		pacco use contribute to es 2 ☐ No 3 ☐ Pro	V
Sor	w requir	ietec		-		
of Vital Records,	The lay ate has page 2	Completed		24a. Was ar autops perforn	y prior to co ned? death?	opsy findings available ompletion of cause of
ita	ien: Trificat	0	25. Was case referred to medical 26. Place of Dea	th (Check only one		2 No
>	ding Physicien: n. After this certific funeral director,	To B			nce 6 XOther (Speci	(fy) AT SCENE
	Jing P	on:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe ho	w injury occurred	
Division	teatl leatl tor: the	icat	3 Suicide 6 10 Could not be	Unknown		10
Di	or fre in t	Certification:	4 ☐ Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at home	City or Town	reet and Number of Rur , State) 2688 Dul	aney St.
	Hospitel	dical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	Baltimore, and due to the ca	uise(s) and manner as s	stated.
	To the Hospitel or Ai within 24 hours after of To the Funerel Direct completely filled in by	a l	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, da	ate and place, and due t	o the cause(s)
	To To con	Σ	29b. Signature and title of certifier OCME		ed. Date signed (Month, PRIL , 20	
			Tablu aconica-Tollering	A	,20	,U 1
			30 Name and address of person who completed cause of death (Item 23a) (Type, Print) THE CAN AND N. CA = VOI N. CA = 111 Penn Street, Balt	imore. M	arvland 212	201
W.	® Sta	te	31. Date filed AMOND, Sex, Seas 1004		J	
	Registr	ar .	TO LOUT PROPERTY AND AND AND AND AND AND AND AND AND AND			

		•	For State Registrar	State of M	laryland /		rtment of H		Mental Hy	giene 2	004	13452
	Discortist.		Decedent's Name (First, Middle, Las						2. Date of De		Year) /	3. Time of Death
	Physici /Medic	cal	4a. Facility Name (If not institution, give	Street and number			4b. City, Town, or	I ocation of De	HYCII	4c. Cour	nty of Death	19:3/14
	Examir	ier	Franklin squar	Q #05 F	ital		Rose	da/ (Bo	Itim	101e
i	Funeral		5. Social Security Number 6. Se	x 7. A	ige (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		y, Year)	Cour	-
- 1	Director		215-12-8930 Usual Residence of Decedent		81				12/24/1	923		yland 10d. Inside City Limits
	lanylan show	j.	10a. State 10b. County		10c. City, To							1 X Yes 2 ☐ No
	ith the Marylar or 28a-f show	Director	Maryland 10e. Street and Number		Balt:	LMOre	10f. Zîp Code			10g. Citizen o	of Whal Cour	ntry?
	death with the Maryland ms 23a or 28a-f show r.mval.be notified at		422 N. Luzerne Ave			40.1	21224	in a contained	(Canada Van as N	U. S.	A.	nan Indian
	ē 🙎 🖺	Funeral	11. Marilal Status 1X Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 Yes 2	3?				(Specify Yes or No erto Rican, etc.)	В	lack, White,	
Š	13-UU30 72 hours after "natural", or ite	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			Yes 20 No	Specify:		Spe	Wh	ite
45,002	within 72 then.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4o		(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of w	vorking	16b. Kind of	Business/In	laustry
3 5	filed within Hygiene, other than vent, Ire M	Com	6			erch	ant Marir		ame (First, Middle			hipping
3	yiand ould be fill Mental H warked oth	To Be	17. Father's Name (First, Middle, Last) Samuel Amos Reed	7					e Curry	, максеп эшп	arrie)	
50	and and and and and and and and and and	F	19a. Informant's Name/Relationship (19	9b. Mailir	g Address (Street		Rural Route Numb	er, City or Tov	vn, State, Ziç	Code)
	item 27 other tra		Frances B. Reed (S	Sister-in	20b. Place	of Dispo	ett Court		1 Essex		land 2 on - City or To	
Sed	Pages Pages nent of h		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		10		natory`or other plac unt Crema		4/28 2004	Baltin	ore.	Maryland
X	battimol perrit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licen		Greek	22 B	. Name and Addre	ss of Facility	al Home	PA		
	n goesa		23a, Part1. Enter the disease, or com	plications that caus	ed the death. D	1	<u>407 old E</u>	Eastern	Avenue	Essex,	Maryl	and 21221 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	line.		te Ana		\sim			Interval Between Onset and Death
	/Medical Examiner		resulting in dealh)	Due to (or a	as a consequenc				170 111			0 -0.5
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consequenc	e of):						
N	60, be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequenc	- of\.						
` 3	876U, ate be ex physician a		l l	d	as a consequenc	o 01).						
	687 rtificate I	Medical	IF FEMALE:	. d.								
	Division of Vital Records, P.O. Box 68 or attending Physician: The law requires that the death certifically death. Director: After this certificate has been signed by the attending plain by the funeral director, page 2 should be detached for use as I in by the funeral director, page 2 should be detached for use as I	Physician/M	23b. Was decedent pregnant in the past 12 months?		ne of pregnancy 2 ☐ Fetal dea at time of death		Ectopic pregnancy Other (specify)	у		1	Date of delive Month	ery Day Year
	IS, P.O.	hysic	1 Yes 2 No 9 Unknown	9□ Unknown	<u> </u>							
	IS, F	by	Part II. Other significant conditions of			g in the u	nderlying cause giv	ven in Part I.		tobacco use c Yes 2 □ No		the cause of death?
	cord	Completed		wisceedly		0 101	שומי של	دمدم	24a. Wa	an 24	b. Were auto	opsy findings available
1	Rec The law tte has	фшо	Deguia						- auto perf 1 ☐ Yes	psy ormed? 2 No	death?	mpletion of cause of 2□ No
g [Division of Vital Re tor Attending Physician: The letter death. Director: After this certificate he in by the funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:			- 317 DOA Ot	200	Death (Check only			
	g Phys er this e	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of I		Outpaties o. Time o Injury	N 3 DOA	ry at	9 Home 5 ☐ Res 28d. Describe			TY)
	ision ttending death. ctor: Afte	catio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n			M 1	Yes 2□No	29f Leasting	(Stroot and No	mbor or Pru	al Route Number,
	Divi	Certification;	4 Homicide determined	28e. Place of building,	etc. (Specify)	, iarm, st	eet, factory, office			wn, State)	niber or run	ai nobie itamber,
	Division of Vital Records, P.O. Box 68/6U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	(Check only 2 Medical Exal	nysician: To the be niner: On the basis	s of examination	dge, deat and/or in	h occurred at the ti vestigation, in my o	me, date and pla opinion, death o	ace, and due to the courred at the time	cause(s) and date and plac	manner as s ce, and due t	stated. to the cause(s)
	o the vithin 2 o the	Med	29b. Signature and title of certifier	and manner	stated.		29c. Licens			29d. Date sig	ned (Month,	Day, Year)
	~ > m 0		> Me weel	Lusaui	كلية		Dis	1667		04-1	!7-2	004.
			30. Name and address of person who	completed cause of	of death (Item 23	a) (Type,	Print)	1= DA	BALTINA	DE M.	1.212	237
	S	tate	31. Date filed (Month, Day, Year)	32. Reg	OO FRA L istrar's Signature	IC II	N GUAR	C UK)	BAITIMO	KE 1010	1 1	
	Regis	trar	APR 2 8 2004	Bene	me 19	je	parked	6				

			1 - For Amend Item #19a peratent of Many 1985 / 1	Pepaytment of Health and M Certificate of Death	lental Hygiene Reg. No.	2004 13453
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	
	Physici /Medio		Shirley Norman Rodman		April 23,	
	Examin	er	4a. Facility Name (If not institution, give street and number) Heritage Harbor Health & Rehab	4b. City, Town, or Location of Death Annapolis		County of Death Inne Arundel
- 4	Funeral	-	Social Security Number 6. Sex 7. Age (In yrs. last bir	rthdey) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yeer)	Birthplace (State or Foreign Country)
	Director		216-14-8747 10M 20F 101	Yrs. Months Days Hours Min.	2/22/1903	Lithuania
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	m or Location		10d. Inside City Limits
	Mary Ind	to	MD Anne Arundel Annar	nolis		1 ☐ Yes 2 ☐ No
	or 28s	lirec	10e. Street and Number	10f. Zip Code	10g. Citiz	zen of What Country?
	ath wi	raic	776 Eastern Point Road	21401	US	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or flams 23e or 28s-f show dother than "natural", or flams 23e or 28s-f show event, ital Medical Examinational by patified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-0	72 ho	eted	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kir	nd of Business/Industry
121	within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Secretary		Government
	e filed within al Hygiene. other than vent, It a Me	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden	
ılan		To B	Abraham Max Norman	Bella N	orman	
Maryland	s 1 and 2 should f Heelth and Men frem 27 le marke other traumatic		PhyLlis Krasner	. Mailing Address (Street and Number or Run		
	s 1 and if Heelth Item 27 other t		20a Method of Disposition 20b. Place o			s, Maryland 21401_cation - City or Town, State
Baltimore,	permit. Pages Department of t Important: If Ite any injury or of		1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemete	ory, crematory or other place) David Mem. Park 4/27		
altir	mit. F partme portan r injur		21. Sign ture of Funeral Service Licensee	22. Name and Address of Facility Nat		ls Church, Virginia al Home
ä	Depa Impo any it	d	empi terbart Mo1338	7482 Lee Highway,	Falls Churc	h, Virginia 22042
3			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		Y/S
	Examiner		Due to (or as a consequence	Se Livi		mantis
	7 2	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of).	,	1
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence resulting in death) Last Due to (or as a consequence	sculd allider		days
60,	ate be executed hysicien and the burial-transit	cal E	Due to (or as a consequence	or).		50
68760	ificate g phys		d			
.O. Box	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
S, P	The law requires that the ate has been signed by th bage 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting i	in the underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
ords	w require been sig should b				1 ☐ Yes 2 €	No 3 Probably 4 Unknown
Vital Record	e law n has be je 2 sh	ompleted			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al H		O			performed?	death? 1 ☐ Yes 2 ☐ No
		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	Other	h (Check only one) me 5 Residence 6	S □Other (Specify)
ion of	After	ertification: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Yeer) 2 Accident investigation		28d. Describe how injury	
Division	itel or Attend rs after death al Director: , ed in by the f	O	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in b	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledgr (Check only one) 2 Medical Exeminer: On the basis of examination are and manner stated.	e, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)
	Vithin To the	Me	29b. Signature and title of confrier	29c. License number		e signed (Month, Day, Year)
	,1		N. John J.	041978	4-	24-2004
	1)		30. Name and address of person who completed cause of death (Item 23a) Na det Jalaks I: HIDD M.T. 31. Data filed (Month Caus Years) 32. Registrat's Signature	(Pepe, Print)	2 BOWSE	MA 20716
1	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 8 2004			
DH	IMH 17 Rev 1/2	001	1 / /	RIGINAL		
				r mores 34 May		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer Telvin Reese 2030 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number Age (In yrs. last birthday) Birthplece (State or Foreign
 Gountry) 6. Sex 15**3**M 2□ F 215-60-3031 50 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Sayes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 814 21205 uzerne Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Mever Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ezekiah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mem 21. Signatura of Funeral Service License 22. Name and Address of Parelity Moh 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Gastrointestina resulting in death) Due to (or as a consequence of): irrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA

/Medical P.O. Division of Vital Records,

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be xecuted the attending physician signed by has certificate After this ospital c. 24 hours after deal... Preal Director: After within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Funeral

Director

or Items 23s or 28s-f show

other traumatic event, the Medical Examiner must be natified at

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 3 eny injury or other traumatic event. The Moderal Eventures.

Physician

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

Examiner

Physician/Medical

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Completed

Be

Certification; To

Medical

27. Manner of Death

1 X Natural 2 Accident

3 Suicide

the Maryland

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Medical

5 Pending

investigation

6 Could not be determined

28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

Res - 000

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Soo Hyun Kim 31. Date filed (Month, Day, Year) 600 North Wolfe Street, Baltimore, Maryland 32. Registrar's Signature

28a. Date of Injury (Month, Day Yeer)

APR 2 8 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April 22, 2004 2:26 A Elizabeth Jennie Rhoten /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/ABaltimore City Date of Birth (Month, Day, Year) Good Samaritan Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 🗆 M 76 June Maryland Director 219-22-7608 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or liems 23a or 28a-f show traumatic event, the Modical Examinar must be restilled at 1 X Yes 2 □ No Balitmore City N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21206 5924 Eurith Avenue death v Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status be filed within 72 hours after di lal Hygiene. d other then "natural", or Item 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store 9 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked otha any injury or other traumails and 17. Father's Name (First, Middle, Last) Be 01ive Merel Webbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21206 Sterling Rhoten (Husband) 5924 Eurith Avenue 20b. Place of Disposition (Name of cometery, crematory or other place) 4/26/04 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore-Washington Crematory Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 23a. Part. Ent. he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. suth Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1915 ZZXLIWYY Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 mo ths? 1 ☐ Yes 2 No 9 ☐ Unknown for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 1 Yes 2 No page 2 1 Yes certificate Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director. Be Hospital: 1 ☐ Inpatient Other: 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1□Yes 2No 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? After Natural 5 Pending 1 🗌 Yes 2 🗌 No investigation within 24 hours after death. To the Funeral Diractor: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7672 Bellen seenge 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 8 2004 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 U 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month April 25, Rock 2004 3:08 am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 🔀 M 2 🗆 F Months Hours Director 219-18-6170 June 19. 1925 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location Department of Health and Mental Hygiene importent, or Items 23e or 28e-f show importent: if item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumettc event, the Modical Examinat must be notified at appear. Dones. 10a, State 10b. County 10d. Inside City Limits MD Director Baltimore Towson 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6451 North Charles Street 21204 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or ite 1 Never Married 2 Married 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify: White 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law 12 Police Officer Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Joseph Rock 2 Reba Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15009 LaVale Road Monkton, Maryland 21111 Benton/daughter Donna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 04/29/2004 Parkville, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. S. Coster 1050 York Road Towson, Maryland 21204 23a. Part. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner arten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a be Examiner nsequence of): that initiated events resulting in death) Last Due to (or as a consequence of): as the burial the attending physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ē in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by to d be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? þ 1 Des 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an vascular 2 No 1 Yes

Division of Vital Records, P.O. Box certificate has this After death.

Be ical Certification: To Hospitel or Attending within 24 hours after death To the Funerel Director: To the

25. Was ase referred to medical examiner?

1 Yes 2 No 27. Manner of Death 1 De Natural

5 Pending 2 Accident

3 Suicide 4 Homicide

(Check only one)

6 Could not be determined

Hospital: 1 Apatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

57

28c. Injury at Work?

3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BALTIMORE

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) APRIL 26, 2004

30. Name and address of person who complete cause of death (Item 23a) (Type, Print 6701 MD

31. Date filed (Month) Year) 8 2004 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

		•	For State Registrar	State of Maryla	and / Depa <i>Ce</i>	artmen <i>rtificat</i>	nt of H	ealth and l Death	Mental Hy	giene 2	2004	13457
-	Physicia	an	1. Decedent's Name (First, Middle, Last) Rose Rocchi					_	2. Date of Dea Month April 2	Day 200	Year	3. Time of Death 8:00 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City,		Location of Deat		4c. Cou	unty of Death	
			Stella Maris 5. Social Security Number 6. Sex		rs. last birthday)	If Under	Tir r1Year	nonium If Under 24 Hrs.	8. Date of Birt	h	Baltimo 9. Birthp	lace (State or Foreign
	Funeral Director			V	00 Yrs.	Months	Days	Hours Min.	Jan. 1,	1904	l Coun	taly
	land ow	}	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					1	0d. Inside City Limits
	e Man	ctor	Md. Balti	more			nium					1 ☐ Yes 2 ☐XNo
	with the	Dire	10e. Street and Number 2525 Pot Spring	Road 1404		10f. Zip		21093		10g. Citizen	of What Coun	itry?
	death	Funeral Director		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dece If Yes, spe			pecify Yes or No o Rican, etc.)	- 14. [Race - Americ Black, White,	
36	rs after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💽 No If Yes, Give Year or Dates:		1 🗆 Yes		Specify:			ecity: Whi	te
2-00	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Modical Exercities could be rediffed at	eted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usu	al Occupa	ation furing most of wo.	rking	16b. Kind o	of Business/Inc	
121	e filed within al Hygiene. I other than "vent, ire Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		omema)			Own Ho	ome
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or tiems 23s or 28s-1 show other traumatic event. Its Moulcal Exacilizer traumatic event.	Be	17. Father's Name (First, Middle, Last)						ne (First, Middle,		mame)	
ryla	should be nd Mental nmarked o	10	Francesco Gianr 19a, Informant's Name/Relationship (Ty)		19b. Maili	ng Address	s (Street a		erine Ra ura <i>l R</i> oute <i>Numb</i> e		own, State, Zip	Code)
	and 2 s lealth an m 27 la her trau		Mrs. Velma Peri/Dau	ighter	2525	Pot S	prin	g Rd. L4	04 Timor	ium, N	Marylar	nd 21093
ore	iges 1 and of Herror or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cre			I	Date (20.40.4		on - City or To	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		* 4 □ Donation 5 🛣 Other (Specify) 21. Signature of Funeral Service License	200					/30/04 uck Tows			lome, Inc.
ĕ	Depar Impor any ir		Muchaely	Durch				Road T	owson, №	larylar)4
			23a. Part1. Enter the disease, or condi- shock, or heart failure. List only or Immediate Cause (Final	cations that cadsed the di	eath. Do not en	ter the mod	de of dying	g, such as cardia	or respiratory a	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a c	uence of):	; e fer	Les Ze	2		7.		
(2)	Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	7-7-6							
M.	cuted	Examiner	Cause (Disease or injury that initiated events									
.00 A.	cate be executed physician and the burial-transit	ai Ex	resulting in death) Last	Due to (or as a cons	sequence of);							
·· (D	ifficate g physias the	ledlcai		0.000						10000		
4 β Box	it the death certifii by the attending pached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3[⊒Ectopic p				23d.	Date of delive Month	ory Day Year
0.	the de by the a ached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	ordeath 5t	Other (s	респу)					_
S, F	es tha gned be de	þ	Part II. Other significant conditions cor		resulting in the	underlying	cause give	en in Part I.		obacco use d Yes 2 □ N		ne cause of death?
$\overline{}$	aw requir as been si 2 should	Completed	1/2×10/12						24a. Was		4b. Were auto	psy findings available impletion of cause of
A. C.		Com				<u></u>			perfo	rmed?	death?	2□ No
35	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	2 ☐ ER/Outpatie	nf 3□ D	Othe	200	ath <i>(Check only d</i> Home 5 ☐ Resi		Other (Specif	
ROCCHI	ding Phys h. After this tuneral di	on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year		of	28c. Injury Work		28d. Describe	now injury oc	ccurred	
	C # 1. 0	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st	M treet, factor		Yes 2□No	28f. Location (Street and N	umber or Rura	I Route Number,
ROSE Divi	Hospital or 24 hours after Funaral Director filled in the tely filled in the tell filled		4 Homicide	1								
7	To the Hospital or Atta within 24 hours after de To the Funaral Directo completely filled in by th	edical		sician: To the best of my ner: On the basis of exam and manner stated.								
	To the within 2 To the comple	Me	29b. Signature and the of ceptifier	6/2 1	25	29	9c. License	number			igned (Month,	
	1		30. Name and address of person who co	ompleted cause of death /	Item 23a) (Tvna	, Print)				7	200	
_			EDDIE NAKHUDA, M	.D 2300 DUI	LANEY VA		ROAD	TIMONI	UM, MD 2	21093		
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 8	32. Registrar's Si		dos	W.	-				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** MARTIN SCHWEMMER 3:10 P. N 27, APRIL 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTO., GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex XX M 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 81 214-16-9185 Director 11-17-1922 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits TOWSON 1 ☐ Yes XX No MD. BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **PROVIDENCE** 1229 ROAD 21286 U. S. A. deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XIX Specify: WHITE XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filad within 72 h Hygiene. other than "natu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
12 YEARS College (1-4or 5+) MERCHANT MARINES ENGINEER permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BRUNO SCHWEMMER EUGENIE KUBICHEK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL L. PURVIS (DAUGHTER) 243 FALLS BROOK ROAD, TIMONIUM. MARYLAND, 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State 04-29-2004 DULANEY VALLEY M.G. TIMONIUM, MARYLAND ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician MEASTATIC PRESTATE Concor cons /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician an/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year Physici 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ba detached 9□ Unknown 9 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy performed? 1 🗌 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Special Concession) 2. No 은 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 27 2004 CVVD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles St Baltimore MD Zizo4 ny Charles 32. Registrar's Signature State Registrar

chwemmer Martin

			For State Registrar		State of M	/laryland		artmen tificat			and M		Reg. No. (200	-	13459
	Physici	an	Decedent's Name (210						2. Date of De	ath Day	Yee		3. Time of Death 2:12AM
	/Medic		Sara		<u>-</u> _	ZZio			-		()	April	27	200 County of De		2.12/1
	Examir	er	4a. Facility Name (If n	Region		pital			Lau				P	rince	G	ieorge's
	Funeral Director		5. Social Security Nur 062-03-027	70	7]M 2🖽 F	Age (In yrs. Ia 88	est birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	8. Date of Bir (Month, Da Sept. 2	8,191	.5 N	irthplac Country	e (State or Foreign York
	and w		Usual Residence of D	Decedent 10b. County		10c. City	, Town or Lo	cation							10d	. Inside City Limits
	Maryli faho	ro	MD	Montgom	ery	Si	llver	Sprin	.g							1 ☐ Yes 2 ☐ No
	r 28a	Ireci	10e. Street and Numb	per				10f. Zip					10g. Citiz	en of What (country	?
	th with	a D	410 Torrir	ngton Pla	ce			2	0901				USA			
9	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f ahow importants if item 27 is marked other than "natural", or items 23a or 28a-f ahow hiptry or other traumatic avent, the Modical Exaction in that he rottlind at ance.	Funeral Director	11. Marital Status 1 Never Married	d 2 ☐ Married	12. Was Decede Armed Force 1 Tyes 22	ş? ⊒No		Was Deced f Yes, spec 1 Yes		ispanic Ori n, Mexican Specify:	gin? (Spe 1, Puerto I	cify Yes or No Rican, etc.)		4. Race - An Black, Wh Specify:		2.
003	ural'.	d by	3X Widowed 4		If Yes, Give Year or Date	s:										
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Maryland	12 sho		19a. Informant's Name Anthony E.					•				/ Route Numb				ode)
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B	permit. Departr Imports any inji		Keny	a Soloan	# WO13	38	7	601 S	andy	Spri	rie Ing R	ck Fundous L	erai aurel	Home, Mary	1nc	nd 20707
6	Physician		Immediate Cause (F	failure. List only o inal	lications that cause on each	sed the death line.	Do not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory a	rrest,		Ir	pproximate hterval Between inset and Death
	/Medical Examiner		resulting in death)		Due to (or	as a consequ	ience of):			0.		1	0			
		-E-	Sequentially list cond if any, leading to imm cause. Enter Underh	ditions, nediate	b. Due to (or	as/a consequ	ence of):		RVC	200	× C-	gai	M	10	+	
	uted d ansit	cal Examiner	cause. Enter Underly Cause (Disease or in that initiated events	ying njury	6	AO	vh'		Va	lv.	2 1	Rebl	2cer	vel .	ļ	
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x 68	ertifica ling pl	Med	IF FEMALE:		23c. If yes, outcome	me of pregnar	201				-			0.1 D-1(-	-15	
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Med	23b. Was decedent in the past 12 m 1 ☐ Yes 24☐ 9 ☐ Unknown	pregnant nopths?	1 Live birth	2 Fetal t at time of de	death 3	□Ectopic pi □ Other (sp						3d. Date of d Month	D	ay Year
٥	w requires that the been signed by should be detac	y Ph	Part II. Other signific	cant conditions co	ntributing to deat	h but not resu	ilting in the u	nderlying o	ause giv	en in Part I		23e. Did	obacco us	se contribute	to the	cause of death?
Records,	n sign											1 🗆	Yes 2	□ No 3 □	Probab	ly 4 @Unknown
000	awre s bee 2 sho	Completed										24a. Was		24b. Were	autops	y findings available eletion of cause of
		E										perfo 1 ☐ Yes	rmed?	death	?	B No
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referre	-	14	/			- 01		-	(Check only				
of V	S S	2	1 ☐ Yes 2 Ž	10	Hospital: 1 ⊟tnp		ER/Outpatier					me 5 Resi			ecify)	
on C		lon:	27. Manner of Death 1. SNatural	5 Pending	28a. Date of I (Month,	Day Year)	28b. Time of Injury	M A	28c, Injun Worl	ya≀ k? Yes 2. □		28d. Døscribe	now injury	occurred		
Division of Vital	Attending r death. sctor: Attel	Certification:	2 Accident 3 Suicide	6 Could not be	289. Place 01	Injury - At ho	me, farm, str					28f. Location (Pural P	Route Number,
Οį	after Dire	erti	4 ☐ Homicide	dotominod	building	etc. (Specify	')					City or To	wn, State)			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C		Certifying Phy		s of examinat										
	To the within 2 To the comple	Me	29b. Signature and	itle of certifier		3 4	01.	29	c. Licens	e number			29d. Date	signed (Mo	nth, Da	ry, Year)
	1			1101	UII	V (choi		D 51	-40	3		4/2	17/2	5-04	7 -
	5		30. Name and addre	ss of person who o	ompleted cause	of death (Item	23a) (Type.	Print)	QUE	非26.	0,77	TKOMA	3º19Pl	L, W	D 2	.0912
	St	ate	31. Date filed (Month	n, Day, Year)	52 33. Rea	istrar's Signat	ture Loo	eks								·

			riease	State of Maryla				-		_		
		•	For State Registrer	State of Maryla		rtificate of			Reg. No.	004	1346	0
_			Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ath		3. Time of Dea	th
	Physicia /Medic		Stephen Seneca	Sharp				April	17	2004	0335	М
	Examin		4a. Fecility Name (If not institution, given	e street and number)		4b. City, Town, o	r Location of Deatl	h	4c. C	ounty of Death		
			Harford Memoria		- Jack birdhida il		de Grace	9 Date of Birth	b	arford	place (State or For	roian
	Funeral Director			Sex 7. Age (In you	rs. last birthday) 1 Yrs.	Months Days	Hours Min.	02/12/	y, Year)	Mary	intry)	eigi i
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation		_			10d. Inside City Lie	mits
	death with the Maryland ms 23a or 28a-f ahow r must be nutified at	ctor	MD Harfor	d H	lavre d	e Grace					1 X Yes 2 □]No
:	or 28	Director	10e. Street and Number			10f. Zip Code			_	en of What Cou	ntry?	
	s 23e	erai	1409 Superior St	reet 12. Was Decedent Ever in	11 S 13	21078 Was Decedent of H	lispanic Origin? (S	inecity Yes or No-	US . 14	A 4. Race - Ameri	can Indian,	
	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or items 23a or 28a-1 show avent, the Madical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WW		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No		o Rican, etc.)		Black, White		
Maryland 21215-0036	72 hou natura lical E		15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	rking	16b. Kind	d of Business/Ir	ndustry	
2	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					Sale			
מ	filed w Hygier Sther tt		17. Father's Name (First, Middle, Las	4 years	Sale	s Manage		me (First, Middle,				
an	lid be rked c rked c	To Be	Cyrus Clifford S	harp			Annie	Seneca	Gree	nleaf		
ary	2 should be filed von the street of the stre		19a. Informant's Name/Relationship		19b. Maili	ing Address (Street	and Number or Ru	ural Route Numbe	er, City or	Town, State, Zi	p Code)	
Σ,	and 2 ealth m 27 her tr		Jacqueline H. Sh			Superior		vre de		e, MD ation - City or T		
ore	iges 1 nt of H : If Ite or otl		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3	_Hemoval from State		osition (Name of matory or other place						
Baltimore,	iit Pa arimer orient injury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		2	ris & Co 2. Name and Addre	ss of Facility			Cheste	er, PA	_
Ba	permit Pages 1 and 2 should be Department of Heath end Menta Importent: If Item 27 is marked any injury or other traumatic av 20168.		Vibria n	5my		itchell-Sr 23 S. Wa	nith Funshington	eral Hom . Havre	ie, P de C	A. Grace.	MD 21078	3
			23a. art1. Enter the disease, or conshock, or heart failure. List only	nplications that caused the d							Approximate Interval Between	1
	Pnysician		Immediate Cause (Final disease or condition	ResPIR			lure				Onset and Death	n P
	/Medical Examiner		resulting in death)	Due to (or as a cons								
	LXdillilei	<u>.</u>	Sequentially list conditions,	b. COPD Due to (or as a cons	sequence of):						years	
	d f insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. First Incertying Cause (Disease or injury that initiated events	Pul Ma	NAR	V FIE	3R051	S			vear S	
ó	ie be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):	, , , , ,					7	
3760,	~ ~ ~	lical		d						-		
× 68	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pre	onancy				22	3d. Date of deliv	1901	
P.O. Box	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnanc □ Other <i>(specify)</i>	y		23	Month	Day Year	
σ.	s that the	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the t	underlying cause giv	ven in Part I.	23e. Did to	obacco us	e contribute to	the cause of death	?
rds,	iw requires that s been signed b should be det	ed b	CORONAR	Y ARTER	y Dis	SEASE		1 🗆 Y	(es 250	No 3□Pro	bably 4 ∐Unkn	own
eco	law re as bee	Completed		NAL OBS	/			24a. Was autop	sy	prior to co	opsy findings avail empletion of cause	
Œ Œ	The cate h	Соп							rmed? 2 No	death?	2 🗆 No	
Vita	ician: certific	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only o		T01 - 10		
ō	Phys r this ral dia	1: 70	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	of 28c. Injur	ry at	lome 5 ☐ Resid			ny)	_
ion	Attanding Physician: ir death. ector: After this certifice by the funeral director. it	ation	1 Natural 5 Pending 2 Accident investigation		r) Injury	Wo M 1□	Yes 2 □ No					
	= 9 = -	Certification;	3 Suicide 6 Could not determine			treet, factory, office		28f. Location (S City or Tow		Number or Rur	al Route Number,	
	To the Hospitel c within 24 hours at To the Funeral completely filled in	Medical C		Physicien: To the best of my entiner: On the basis of exam and manner stated.								
	To th To th compl	Me	29b. Signature and title of certifier	1 1108		29c. Licens		1		signed (Month	-	
	110) Ju	0 1000	X	D:	3559	7	41	118/0	4	
/	011		30. Name and address of person who	completed cause of death (Item 23a) (Type		ALIONI F	ave HA	uRe	deGr	Ace, M	D
	Sta	ato	31. Date filed (Month, Day, Year)	Registrar's Si	ignature	,0,00	3,3,0				•	
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 8 20	04	the Son	and I						

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SHArp, STEPHEN

			For State Registrar	State of Mar		artment of H		Mental H	ygien Reg. N	.2004	134	61
	Physici	an	Decedent's Name (First, Middle, L.			Congol		2. Date of D Month April		Year Year	3. Time of I	
ı	/Medic	al	Dana	Maris		Sensel 4b. City, Town, or	Location of Death			c. County of Death	5:30	УW
П	Examin	er	4a. Facility Name (If not institution, g.	_				n			.	
	Funeral		118 Baptist Roa 5. Social Security Number 6.	Sex 7. Age ((In yrs. last birthday)	Hanco	If Under 24 Hrs.	8. Date of E	Sirth	Washingto	ace (State or try)	r Foreign
	Director		220 26 5572	1 M 2 K	73 Yrs.	Months Days	Hours Min.	8. Date of E (Month, I Dec. 2	9, 1	930 Mary	land	
	pu k		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or Lo	ocation				11	Od. Inside City	v Limits
	Aaryla r sho	5	MD Washing		Hancock						¹ √Z X ^{es}	
	28a-	Director	10e. Street and Number	70.00		10f. Zip Code	_		10g. C	itizen of What Coun	try?	
	d within 72 hours after death with the Maryland jene. r then "naturel", or Items 23a or 28a-f show Ite Madical Exam recrust be motified at	I D	118 Baptist Roa	đ		2175	50			U.S.A.		
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of His	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No Rican, etc.)	10-	14. Race - Americ Black, White,		
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 🙀 No	Specify:			Specif W hite		
Ö	hour turel'		3 Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	16a, Dece	dent's Usual Occupa	ation		16b.	Kind of Business/Ind	lustry	
15	n "na	plet	(Specify only highest g		(Give	kind of work done d DO NOT use retired;	luring most of wor	rking			,	
212	77 75	Completed	10	College (1-401 57)	(Cook			Fo	od servic	е	
b	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Las				18. Mother's Nar					
Maryland 21215-0036	Men Men	2	George David		405 14.95			Blanch			Codel	
Mar	d 2 sho h and 7 is m treum		19a. Informant's Name/Relationship Douglas C. Sense			ng Address (Street a						11
	is 1 and 2 of Health a item 27 is other tree		20a. Method of Disposition	L	20b. Place of Dispo	osition (Name of		Date	4	ocation - City or To		
nor	Pages nent of int: If it		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		St. Thoma	matory or other place as, Church	9/ 4/28	3/2004	Ha	ncock, MD		
Baltimore,	글 튼튼을 .		21. Signature of Funeral Service Lic		Cer	netery 2. Name and Addres lelsley-Jo	s of Facility	morel i				
ñ	Depa Depa Impo any i		lib Por	2000 MC		95 Union S					411	
760,	Wedical Examiner on principle of principle o	ical Examiner	23a. Part1. Enter the disease, or constock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. If all more process	a. END ST Due to (or as a constant of the con		NAL DIS					Interval Betw Onset and D	reen eath
P.O. Box 68	The law requires that the death certificat the has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>				23d. Date of delive Month	-	'ear
	quires that n signed b uld be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause give	en in Part I.		tobacco Yes 2	use contribute to th	e cause of de ably 4 ⊟Ui	
Vital Records,	The law requir ate has been si page 2 should	Completed						24a. We aut per 1 Yes	opsy formed?	death?	osy findings a npletion of ca 2 No	vailable luse of
/ita	sicien: Th certificate irector, pag	Bec	25. Was case referred to medical examiner?	(in a c		100	26. Place of Dea	ath (Check only	one)			
7	hys his I dii	၉	1 ☐ Yes 2XX No	Hospital: 1 Inpatient	100000000000000000000000000000000000000		4 🗆 Nutsing r			6 ☐Other (Specify)	
Z Z	Jing F	lon:	27. Manner of Death 1	28a. Date of Injury (Month, Day 1	Year) 28b. Time o	Work	(? Yes 2 □ No	28d. Describe	a now mit	ury occurred		
Division of	nl or Attending Pafter death. I Director: After the in by the funera	Certification:	2 Accident III Vestigat 3 Suicide 6 Could not 4 Homicide determine	be good Black of Injury	y - At home, farm, st (Specify)			28f. Location City or T		and Number or Rural te)	Route Numb) <i>91</i> ,
_	Hospita 4 hours Funerel	Medical Co	29a. Certifier Check only one) Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of e and manner state	my knowledge, deal examination and/or in	th occurred at the time	ne, date and place pinion, death occu	and due to the time	e cause(: e, date ar	s) and manner as stand place, and due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License			29d. D	ate signed (Month, L	Day, Year)	
			· ///~			P	005905	5		4/26/	2004	
	Sta Registr		30. Name and address of person where CIACAN (S) 31. Date filed (Month, Day, Year) APR 2 8 200	ROWNE, M	ath (Item 23a) (Type. D 1293 s Signature	Print)	1.11 Ave	Hag	C 757	lowr, m	0 217	142

			1 - For State Registrer	State of Marylan	d / Depa		Health and M	/lental Hygi	•	
>	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last JAMES 4a. Facility Name (If not institution, give	LEON SIN	NOTT		or Location of Death	·	Day 24, 20	Death
	Funeral Director		Frederick Memo 5. Social Security Number 216-14-4340 Usual Residence of Decedent			Freder If Under 1 Year Months Days		8. Date of Birth (Month, Day, Jan. 19,	Frede	rick 9. Birthplace (State or Foreigr Country) Maryland
	72 hours atter death with the Maryland neturel; or Items 23a or 28e-f ehow dicel Examinatinations to notified at	Director	10a. State 10b. County Maryland Carrol 10e. Street and Number	1	y, Town or Lo	Union Bri		10	∂g. Citizen of Wh	10d. Inside City Limits 1 ☑ Yes 2 ☐ No at Country?
136	s 1 and 2 should be filed within 72 hours after death with the Marylan fellential and Mental Hygiene. I fleatith and Mental Hygiene in the fleat 28 or 28e-f ehow fellen 27 is marked other then "neturel", or fleams 28a or 28e-f ehow other treumatic event, the Medical Examinating is use the notified at	Funeral	5 W. Locust St 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	• 12. Was Decedent Ever in U. Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates] 942-4			21791 Hispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race -	S.A. American Indian, White, etc.
121	filed within 72 hou Hygiene. Ither then "neture int, the Medical E	Completed by	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retire				government
aryiand	2 should be filk and Mental Hy Is marked oth sumatic event	To Be	17. Father's Name (First, Middle, Last) James Leon Si 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailin	g Address (Street		e (First, Middle, M n Gernand al Route Number,	l	
a)	0 0		Naomi Sinnott/ wi 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. P	lace of Dispo emetery, cren	Locust sition (Name of natory or other place) Y Cremat				ty or Town, State
Balti	permit. Pag Department Importent: I eny injury o		21. Sign fur of Funeral Service Licens A Hause 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o). Xler Bler	22	Name and Addre	ess of Facility Har adway L	tzler Fu Union Bri	neral Ho	ome
/on,	/Medical Examiner De privial-fransit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, have leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	uence of):	long Eyli Eyli	snet 5			Interval Between Onset and Death
.O. BOX 60	ine law requires that the death certifical te has been signed by the attending phy bage 2 should be detached for use as thi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	,
ords, r.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the ur	derlying cause gr	ren in Part I.			ute to the cause of death? ☐ Probably 4 Munknown
		e Completed	25. Was case referred to medical				26 Place of Death	24a. Was an autopsy perform 1 Yes 2	prio e j? dea > No 1 □	re autopsy findings available in to completion of cause of th? Yes 2 No
TO UOI	ath. r: After this ce tuneral direc	ation: To B	27. Manner of Death 1 Natural 2 Accident 5 Pending investigation	Hospital: 1 Unpatient 2 1 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other	(Specify)
DIVISION	To the hospitel of Atland within 24 hours after death To the Funerel Director: v completely filled in by the f	ai Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my known	v) wledge, death	Occurred at the tir	ne date and place	City or Town,	State)	or Rural Route Number,
1	within 24 h To the Fur completely	Medical	(Check only 2 Medicel Exami	ner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, death occurr e number	ed at the time, dat	e and place, and	I due to the cause(s)
	5		30. Name and address of person who co Mark Coyne	186 Thoma	s John		Frederi	ck, MD 2	1702	
8.	Sta Registr		APR 2 8 2004	32. Registrar's Signal	ture Const					

		•	For State Registrar	State of Maryla				ealth and	Mer		ene g. No. 2 (100	131	. 63
>	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last Rose Anna Swanke 4a. Facility Name (If not institution, give		ırt	Pa	asade		th	Date of Death Month ()4	27 4c. County	e Arun		0 A4
	Funeral Director		5. Social Security Number 6. Se 220-60-8149	7. Age (In yrs	Yrs.	Months Months	Days	If Under 24 Hrs Hours Min		Date of Birth (Month, Dey, 11/26/1	^{Year)} 952	Count	ace (State or try) land	Foreign
	e Maryland la-f show	ctor	MD 10b. County Anne Art		ity, Town or L a sadena								0d. Inside City 1 🗌 Yes	
	s 23s or 26	erai Dire	10e. Street and Number 1840 Cook Farm Co	urt 12. Was Decedent Ever in	12 13		211		Specify		U.S.A.			
920	ours after death with the Marylan ral', or Items 23s or 28s-f show Exertine mast be rediffed at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	0.3.	If Yes, sp		ispanic Origin? (n, Mexican, Pue Specify:	rto Rici	an, etc.)		ack, White,	etc.	
21215-0036	"natu	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation fe completed) College (1-4or 5+)	(Give	edent's Use kind of w DO NOT	ork done o	during most of we	orking	1	6b. Kind of E	Business/Ind	lustry	
22	be filed ital Hygi id other	To Be Co	17. Father's Name (First, Middle, Last) Harry E. Hargadon,	Sr.	1 111	idilce		18. Mother's Na Rose U				тө)		
			19a. Informant's Name/Relationship (7		1840	Caal	< Far	and Number or F	Pá	asadena	, MD 2	21122		
Baltimore,	permit. Pages 1 and Department of Heelth Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1	Removal from State	2	ematory or Comat 22. Name a	other place	nc. 5/1	tal	04 F lings F	unera	ore, M	D., P.A.	
	Physician /Medical		23a. Part! Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	ath. Do not er	nter the mo	CUV	g, such as cardi	ac or re	espiratory arre	st,	21122	Approximate Interval Betw Onset and D	veen
760,	e be executed sician and purial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse										
.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tel death 3	□Ectopic □ Other (:		,				ate of delive		'ear
۵.	w requires that the s been signed by th should be detache	ed by Pr	Part II. Other significant conditions of	ontributing to death but not re	esulting in the	underlying	cause giv	en in Part I.		23e. Did tob			e cause of de ably 4 □U	
I Reco	> -0 -0	Completed								24a. Was ar autops perform 1 Yes 2	V	prior to cor death?	psy findings a npletion of ca 2 No	ivailable
of Vital Records,	ding Physician: The lav h. After this certificate has funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of Injury	□ ER/Outpatie		OCA Oth	4 🗆 Nursing	Home	The state of the s	nce 6 □Ot		<i>'</i>)	
Division	or Attending tter death. viractor; After n by the fune	Certification:	1 Accident		Injury home, farm, s	M street, facto	10	k? Yes 2 ☐ No	281	. Location (Sti City or Town		nber or Rura	I Route Numb	ber,
	To the Hospital or Attendir within 24 hours after death. To tha Funeral Diractor; All completely filled in by the fu	edical Ce		ysicien: To the best of my k niner: On the basis of exami and manner stated.										1
)	To the within To the compl	Me	29b. Signature and little of certifier	MN			9c. Licens	,		Δ	od. Date sign	2870	206	
	6		30. Name and address of person who	MO 900 BE	Stg are	Print)	d 50	The 300		Anngo	otis /	40 2	149	
	St Regist	ate rar	31. Date filed (Month, Day, Yeal) APR 9 8 200	3. Registrar's Sig	nature	وكلمه								

			1- For State of Maryland / Department of Health and Men Certificate of Death	tal Hygien	- 40	13464
	Physici /Medio Examir	al		4 21	ay Year	3. Time of Death
	Funeral Director	4	1M 2 F Vrs Months Days Hours Min.	Date of Birth Month, Dey, Year	N/A	oplace (State or Foreign untry)
	he Maryland 8e-f ehow	ector	MD N/A Baltimore			10d. Inside City Limits 1 XYes 2 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or items 23a or 28e-f ehow important: If Item 27 ie marked other than "naturel", or items 23a or 28e-f ehow appringly or other treumatic event, the Medical Examiner must be multified at ODGE.	by Funeral Director	10e. Street and Number 2121 Windsor Garden Lane Apt.B422 21207 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 MDivorced 10f. Zip Code 21207 13. Was Decedent Ever in U.S. Armed Forces? 1961 1 Myes 2 No 1 Yes, Sive - 1962 1 Yes 2 No Specify:		U.S.A 14. Race - Amer Black, White Specify: Bla	orican Indian,
21215-0036	d within 72 hour: giene. er than "neturel" . The Medical Ex	Completed b	3 Widowed 2 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12th Merchant Seaman	16b. l	Kind of Business/I	
Maryland	ould be file I Mental Hy sarked oth satic event	To Be (Thomas R. Smith 18. Mother's Name (First, Middle, Last) Marie Ro	oberts		
	and 2 sh ealth and m 27 le m		19a. Informant's Name/Relationship (Type, Print) Daniel Smith - Brother 3730 W. Garrison Ave.	. Balto	., MD 2	1215
Baltimore,	t. Pages 1 rtment of H rtant: If Ite		20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 13 Burial 2 Communic State 14 Donation 5 Other (Specify) 20b. Place of Disposition (Name of Communic State Ring) 21 Communic State Ring (Name of Communic State Ring) 22 Communic State Ring (Name of Communic State Ring) 23 Communic State Ring (Name of Communic State Ring) 24 / 28 / (Name of Communic State Ring)	04 Ba	lto. Co	., MD
Bal	Depa Impo any is		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Nutte 2501 Gwynns Falls	Pkwy.		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resistance, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	spiratory arrest,		Interval Between Onset and Death
1760,	icate be executed physician and s the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
P.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delin	very Day Year
	w requires that s been signed by should be deta	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
al Reco	: The law recate has been page 2 shown	Completed by	Hypertension	24a. Was an autopsy performed? 1 Yes 2 N	prior to codeath?	opsy findings available ompletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	ation: To Be	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			ify)
Divis	tal or Atters after de al Directo	Certification:		Location (Street a City or Town, Stat	nd Number or Rui e)	al Route Number,
	To the Hospital or within 24 hours affer To the Funeral Dir.	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of control of my communication and/or investigation, in my opinion, death occurred at and manner stated.	due to the cause(s t the time, date an	s) and manner as id place, and due	stated. to the cause(s)
)	To with	Σ	29b. Signature and title of certifier 29c. License number Difficial Difficial	29d. Da	ate signed (Month	Day, Year)
	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Chiu n.o. 22 S. Green St. Baltiment no	0 212	10	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature ADD 2 8 2004 ADD 2 8 2004			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #/ per In (831 5/24/04 tas

			For State RegistrarAMFND 1. Decedent's Name (F	111:M #8	7 PER PH C831 PER PH C831	175 /217 0 5/11/04	μΩer JECer	tificate of	Death	2. Date of De.	ath			3465 ne of Death
ı	Physicia			Churchil		son S	Schwe	ring		April	22	2004	8	:35 A ^M
1	/Medic Examin		4a. Facility Name (If no	ot institution, give	street and number)			4b. City, Town, o	r Location of Death	1	4c.	County of De	eath	
П			Maplewood	Park Pl					hesda				gomery	
, ER.	Funeral Director		5. Social Security Num 360–10–822	28 1		9 (In yrs. last :	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y. 8a16	6-1920 ^{1. [}	Birthplace (St Country) Idaho	ate or Foreign
	and		Usual Residence of De 10a. State 10	Ob. County		10c. City, To	own or Lo	cation					10d. Insid	de City Limits
	Maryl -f ehc	ō	Maryland	Montgom	nery			Bethesd	la				1 💢	Yes 2 □ No
	r 28a	Directo	10e. Street and Number	ər				10f. Zip Code			10g. Citiz	zen of What	Country?	
	h with		9707 Old (Georgeto	own Rd.				20814		Uni	ted St	tates	
	eme erre	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		13. V	Vas Decedent of h Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 1	14. Race - A	merican India	n,
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Iteme 23a or 28a-f show event, tha Medical Examiner court, the Medical Examiner court, the modified at	þ	1 ☐ Never Married 3 🛣 Widowed 4 [1 ☐ Yes 2 € ↑ ↑ If Yes, Give X Year or Dates:	No .		☐ Yes 2X No			1	Specify:	White	
7	natu	Completed	15 (Specify	 Decedent's Ed only highest gra 	lucation de completed)	16	Give	ent's Usual Occup kind of work done	pation during most of world)	king	16b. Kir	nd of Busine	ss/Industry	
12	within ane. then	dw	Elementary/Seconda	ary (0-12)	College (1-4or 5	i+)			o inistrat		М	ledici	ne	
7	filed v Hygie other t		17. Father's Name (Fir	st, Middle, Last)			nost	Ital Au	18. Mother's Nan					
au	Mental Mental arkad o	To Be	Cyril C	louse T	Chompson				Vivia	n Grac	e	Ditto		
ary	2 should be filed v n and Mental Hygie 1 e markad other t raumatic event, ib	-	19a. Informant's Name	e/Relationship (7	Type, Print)	1	9b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe	er, City or	r Town, State	e, Zip Code)	
Ž	5 # 12 T		Katherine	Schweri	ng / Daug	hter 3	3 Lor	raine Ct	., Rockv	ille, MD		852		
Baltimore,	of T		20a. Method of Dispos 1 ☐ Bunal 2 ☐ 0 4 🎇 Donation 5	Cremation 3 [Removal from State	20b. Place ceme Unifo	of Dispo- tery, cren ormec	sition (Name of patory or other pla L Service th Scienc	es of Apr	il 22, 004		cation - City ethesd	or Town, Star	ie
alti	permit. Peg Department Importent: I any injury o		21. Signature of Funer	ral Service Licen	1S 00	, , , , ,			ess of Facility al and C	remation	Ser	vices		
<u>m</u>	88 58		Tallet	Johns		00582	93	3 Gist	Ave., Si	<u>lver Spr</u>	ing,		20910	
			23a. Part1. Enter the shock, or heart fa	disease, or com ailure. List only	plications that caused one cause on each fi	I the death. D	o not enti	er the mode of dyin	ng, such as cardiad	or respiratory a	rrest,			imate I Between and Death
	Physician /Medical Examiner		Immediate Cause (Fir disease or condition resulting in death)	nal	a. Due to (or as	a consequence	ce of):	-						UEEX
	Zammer	16	Sequentially list condi- if any, leading to imme cause. Enter Underlyi	tions,	b	a consequenc	ce of):							
	ted nsit	nine	Cause (Disease or Inju	ing ury										
<u>,</u>	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Las	st	Due to (or as	a consequenc	ce of):							
68760,	le be ysicia le bur	edical			d									
-	= O 6	Medi	IE EE MALE.								I			
P.O. Box	The law requires that the death certifi ate has been signed by the attending l bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent print in the past 12 mg 1 ☐ Yes 2 ☑ N 9 ☐ Unknown	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у		2	23d. Date of o Month	delivery Day	Year
٦	that ned by deta	y Ph	Part II. Other significa	ent conditions	ontributing to death b	ut not resultin	g in the ur	nderlying cause giv	ven in Part I.	23e. Did t	obacco u	se contribute	e to the cause	of death?
g	quires n sign	ed by								10	Yes 2	⊒No 3□	Probably 4	4 Unknown
000	aw requir s been si 2 should	Completed								24a. Was		24b. Were	autopsy find	ings available of cause of
æ	The lav	ШО		·						perfo	rmed?	death	res 2□ No	
ta	sician: Th certificate rector. pag	BeC	25. Was case referred examiner?	to medical					26. Place of Dea	ath (Check only o				
<u></u>	hysic his ce I direc	To	1 Yes 2 No		Hospitaf: 1 ☐ fnpatie	ent 2 ER/		T 3L DOA		lome 5 Resi			(pecify)	
Division of Vital Records,	ath. or: After the		2 Accident	5 Pending investigation		ry Year) 281	o. Time of Injury	Wo	ry at rk?]Yes 2 □No	28d. Describe	how injury	y occurred		
Divis	To the Hospital or Attending Physician: The within 24 holys after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 4 Homicide	6 Could not b determined	288. Flace Ul III]	ury - At home c. <i>(Specify)</i>	, farm, str	eet, factory, office		28f. Location (. City or To	Street and wn, State)	d Number or)	Rural Route	Number,
1	Ne Hoseli 1 24 hours Ne Funer pletely filli	edical			nysicien: To the best niner: On the basis o and manner st	f examination								ıse(s)
)	To th Within	W	29b. Signature and titl	le of certifier	es he	10	-	29c. Licen:	se number	5-9	29d. Date	e signed (Mo	onth, Day, Ye	ar)
			30. Name and address					Print)		,		10	110	
_	10				; 8218 Wi			#103,	Bethesda	, MD 20	814			
	Sta Regist		31. Date filed (Month,	Day, Year) 8 2004	32. Registr	ar's Signature		backs	*					
			HERA	V ZUU4	/		1							

		Please			ible ink. Ensure		_	•	
		1 State	State of Maryl		nent of Health and	d Mental Hygier			
		* Registrar		Certifi	cate of Death	Reg. N	200	4 1346	
Physic /Med		1. Decedent's Name (First, Middle, Last	dward	Sociel		2. Date of Death Month	ay Year	3. Time of Death	
Exam		4a. Fecility Name (If not institution, give	street and number)	4b.	City, Town, or Location of De		c. County of De		
		3009 CALIFU	RNIA A	VE .	Parkville		BALTI	MORE	
Funera	_	5. Social Security Number 6. Se	7. Age (In)	CrCV Mo	Inder 1 Year If Under 24 H		9. Bi	intholace (State or Foreign Country)	
Directo		Usual Residence of Decedent		Yrs.		1-2-14	, m	ARYLAND	
arylar	_	10a. State 10b. County		City, Town or Locatio				10d. Inside City Limits	
the Ma 28a-f	Director	10e. Street and Number	MORE		CKVILLE			1 ☐ Yes 2 No	
baitimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other treumatic event, it a Medical Examinar mant to notified at more.	al Di	3009 CALIFO	RNIA AV	10	7. Zip Code 21234.	10g. C	Citizen of What C	Ountry?	
r dea	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13. Was I	Decedent of Hispanic Drigin? specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Am		
S afte	by Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 (No If Yes, Give		es 2 No Specify:	eno moan, etc.)	Black, Whi	ne, etc.	
hour hour	d b	3 Widowed 4 □ Divorced	Year or Dates:				Specify: W	hite.	
ZTZ15-UU36 ad within 72 hours after gjene, er then *natural; or Ite than *natural Exemine	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give kind	Usual Decupation of work done during most of w OT use retired)	vorking 16b.	Kind of Business	s/Industry	
d 212 filed with Hygiene. other ther	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Sole:	RMan	To	Man	Startucio	
be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle, Maide	Sumame)	DIACIUIII	
Maryiand of 2 should be file lith and Mental Hy lith marked oth treumatic event	To E	Peter Joh	oel.		Lucio	TABLI	OSKI		
2 should I and Meni is marker eumatic		19a Informant's Name/Relationship	rpe, Print)	19b. Mailing Add	Iress (Street and Number or	Rural Route Number, City	or Town, State,	Zip Code)	
1 and 1 Health Health em 27 ither trees		tatricia Ka	4- Nieco	9127	Kilbridge he	d. BALTIM	OPEM	1 21236	
Pes 1		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ F	20t	 Place of Disposition cemetery, crematory 	(Name of or other place).	Date 20c. L	ocation - City or		
Pages ment of ant: If it		'4 □Donation 5 □Other (Specify)		Poreland/	Rom. Park 4-	29.04 16	ekville	o ma	
permit. Pages 1 a Department of Hee Important: If item eny injury or othe		21. Signature of Funeral Service Licens	e /	22. Nan	e and Address of Facility	ALTIMOREY.	nb 212	34.	
20200		- Simberly 4	aujotra	EVAN.	S FUNERAL C	HAPEL, 880	WHARI	FORD RD.	
		23a. Part1. Enter the disease, of compleshock, or heart failure. List only of						Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition resulting in death)	ACUTE	MYOCARO	IAU INFARETIO	\checkmark		Driset and Death	
Medical resulting in death) Due to (or as a consequence of): COCON LLY ATTICKS SCICKOS IS									
	क	Sequentially list conditions, if any, leading to immediate			5 CC7C0 \$ 18		-		
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
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rtificate ng phy as the	Medi								
SO THE STATE OF TH						23d. Date of delivery			
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ician: The law requires that the certificate has been signed by the rector, page 2 should be detache	b	Part II. Other significant conditions con	tributing to death but not r	esulting in the underlyi	ng cause given in Part I.		23e. Did tobacco use contribute to the cause of death?		
w require been sign	etec					1 Yes 2	ØN0 3□Pr	obably 4 Unknown	
The law cate has I page 2 s	Completed					24a. Was an autopsy	prior to o	topsy findings available completion of cause of	
						performed? 1 □ Yes 2 ☑ No	death?	2□ No	
	o Be	25. Was case referred to medical examiner?	ospital:			eath (Check only one)			
or Attending Phy after death. Director: Alter this in by the funeral d	—	1 ☐ Yes 2 1 No 27. Manner of Death	1 ☐ Inpatient 2	DDA Wiler 4 Nursing	Home 5 Residence	6 Other (Spec	cify)		
nding tth. :: Afte	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	25d. Describe now into	and the second s		
Attended octor	iffica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At	home, farm, street, fac		28f. Location (Street ar	nd Number or Ru	ıral Route Number.	
s affe	Certification;	4 □ Nomicide	building, etc. (Spec	city)		City or Town, State	ite)		
To the Hospital or Attending Pr within 24 hours atter death. To the Funerel Director: After the completely filled in by the funeral	edical	29a. Certifier 1% Certifying Phys	ician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death occur nation and/or investiga	red at the time, date and plaction, in my opinion, death occ	e, and due to the cause(s urred at the time, date and	and manner as d place, and due	stated to the cause(s)	
o the o the omple	Med	29b. Signature and title of certifier	and marner stated.		29c. License number		29d. Date signed (Month, Day, Year)		
F 5 ⊢ ŏ							april 27, 2004 DO BALTIMOR UD 21234		
(()	3	30. Name and address of person who cou	moleted cause of death /lt	em 23a) (Type Priet)		1	1,	-004	
(0		SERENA R NOLAM	IMP 8831	SATYR HI	LL RD SUITE	100 BALTIA	nor W	0 21234	
Sta	_	31. Date filed (Month, Day, Year)	. 32. Registrar's Sign	nature Asses	Val.				
Registi	ar	ADD 2.8 2004	Begin soin	(2) Pape 1000	CUM				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Miles Smith, Jr. 04-2853 State of Maryland / Department of Health and Mental Hygiene 1- State unpend item#23a,27,28a-f,PER ME,C831-5/13/0388 of Death AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Miles Patrick Smith JR. 18:54 P M /Medical April 26, 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner John Hopkins Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9 / 02 / 1999 Birthplace (State or Foreign Country)
 MD **Funeral** 1**∑**M 2□F 219-55-5536 4 Yrs Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 XYes 2 □ No Director N/A Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3906 Bryony Road 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ir than "natural", or itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 <u>8</u> 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pre-k College (1-4or 5+) Student Education ges 1 and 2 should be filed v t of Health and Mental Hygie If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Miles P. Smith Sr. Nicole Y. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3906 Bryony RD, Randallstown, MD 21133 Nicole Wright/ Mother other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If eny injury or once. ö King Memorial Park Randallstown MD 21. Signature of Eureral Service Licens 22. Name and Address of Facility MD, 21207 Howell Funeral Home 4600 Liberty Heights 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician Curshot Wound To Head** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\text{No} \) death? 1 XYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 280€R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes 2 ☐ No 28a. Date of Injury (Month, Day Year) filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 5:54 p^M 4/26/04 death. subject shot self 2 X Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di residence 3906 Bryony Rd, Randallstown , MD 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anes O.C.M.E. April 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO AMA

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

RUBIO

31. Date filed (Month, Day, Year)
APR 2 8 2004

	1 - For State of M	Maryland / Department of Health and M Certificate of Death	2004 13468					
	Decedent's Name (First, Middle, Last)	C : 11	Reg. No. 2. Date of Death 3. Time of Death					
Physician /Medical	Johnnie M.	Sm.th	Month Day Year 3:11 AM					
Examiner	4a. Facility Name (If not institution, give street and number		4c. County of Deeth					
Funeral		Daltimore Cil Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	9. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)					
Director	251-19-5544 10M 2196	44 Yrs. Months Days Hours Min.	Nov. 23, 1959 South Caruline					
aryland show	Usual Residence of Decedent 10a. State 10b. County /	10c. City, Town or Location	10d. Inside City Limits					
e Many a-fsh iffed	hd N/A	Baltimore	1 DW es 2 □ No					
with the Mar t or 28a-f si te multified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
*** The Maryland with the Maryland within 72 hours after death with the Maryland ene. **** Then "natural", or Items 23e or 28a-f show the Marical Exercites from the collified at ampleted by Funeral Director	11. Marital Status 12. Was Deceder	2/2/8 at Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sc	Decity Yes or No- 14. Race - American Indian,					
after d or Item or Item	1 Never Married 2 Married 1 Yes 20	s? If Yes, specify Cuban, Mexican, Puerto ♣No	D Rican, etc.) Black, White, etc.					
215-0036 thin 72 hours atle en "natural", or Manical Evand	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates		Specify: Black					
121215-00; led within 72 hours by them. It a Marical Ext. Completed b	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Business/Industry					
> N ph = 2	Elementary/Secondary (0-12) College (1-4o	Custodian	Cleaning					
be first Hard of the second of	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Sumame)					
Maryland d 2 should be fill in and Mental Hy ir is marked in treumatic event To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rur	ral Rouse, Number, City or Town, State, Zip Code)					
_ 5 = 0 -	Tammy Smith nlec		Pd. Ballo. Md. 21225					
C 5 85 E 2	20a. Method of Disposition 1 Burial 2 GICremation 3 Removal from State		Date 20c. Location - City or Town, State					
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F-25534	23a. Part1. Enter the disease, or complication at at caus shock, or heart failure. List only one cause on each	ed the death. Do not enter the mode of dying, such as cardiac line.	or respiratory arrest, Approximate Interval Between					
Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a. Tupe C	kalemia	Onset and Death					
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Division of Vital Records, P.O. or Attending Physicien: The law requires that the darker death. In by the funeral director, page 2 should be detached the by the funeral director, page 2 should be detached by the funeral director.	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?					
cord w require been si should b	Dabetes Mellitus, Co	igestive Heart tailure.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
al Records, The law requires the cate has been signed, page 2 should be of Completed by			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?					
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Ntendi death. ctor: A y the fu	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of 1	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number,					
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Divisia To the Hospital or Attenwithin 24 hours after death within 14 hours after death completely filled in by the Medical Certifical	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner:	it of my knowledge, death occurred at the time, date and place, of examination and/or investigation, in my opinion, death occurred totaled.	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)					
To the within To the cample	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
	04/24/04							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
State	Internal	trar's Signature						
Registrar DHMH 17 Rev 1/2001	APR 2 8 2004	See A Agentis						

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permit. Pages 1 ar Department of Hea Important: If item any injury or other		21. Signature of Funeral Service L	to half IV			2. Name and Mit	Addres	ss of Facilit	y edef	eld Fun Baltim	era	ı1 Ho		
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To the within 2 To the complet		1104	() () ()	7 A A	10			/IC			Λn	~-i1 ^) E O	004
Mitt To Con		30. Name and address of person w	the Claude	death (Item	23a) (Type, I	Print)	oa	'IL			АÞ	TTT 2	25, 2	.004

State of Maryland / Department of Health and Mental Hygiene 2004 13470 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Yeer Month Olajire Taiwo April 24 2004 /Medical 9:55 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Mariner Healthcare Prince George's Laurel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Hours 577-76-9840 Director 58 April 17, 1946 Nigeria Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location s 23s or 28s-f show 10d. Inside City Limits Directo 1 X Yes 2 □ No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14815 Ashford Court 20707 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner: 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married ☐Yes 2 XNo ŏ Baltimore, Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 🔯 No Specify: ۾ 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates: "natural" Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th 5+ Teacher High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Jarioqbe Taiwo Abike Aleshinloye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 is Olufemi Taiwo/Son 14815 Ashford Court, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Important: If any injury or once. MD National Cemetery 5/7/2004 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00160 313 Talbott Avenue, Laurel, MD 20707 succe Nanglange 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia /Medical Hours Due to (or as a consequence of): **Examiner** Sequentially list conditions.

Tany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the detached o. 9 Unknown Records, P. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed Elevated Liver Enzymes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 (X No has 24a. Was an page 2 certificate Division of Vital 1□ Yes 2 No To the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 ☐ Yes 2 🔀 No this 3 DDA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56797 April 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laoitha Tadikonda, 13952 Baltimore Avenue, Laurel, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 28 Registrar

Physicia		 Decedent's Name (First, Middle, 	, Last)							2. Date of D				3. Time of Dea
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ineral rector		5. Social Security Number 525–46–0927	6. Sex 1 ☐ M 21 ☑ F	Age (In yrs. lasi 80	Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of B (Month, D Nov.]	lay, Year)		Birthplac Country, Texas	e (State or Fo
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Important: if item 27 is any injury or other trau 2000		21. Sign (u e) of Funeral Service L	(1111)	M01250	22.	Name and	Addres	s of Facilit	Flec	k Fune oad, L	ral l aurel	Home, 1, Mar	Inc.	d 2070
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ij.			Registrar 1. Decedent's Name (First, Middle,	Last)		Tillicate of L	realli	2. Date of Death	g. No.	3. Time of Death
	Physici		RUTH	LEE TA	46 G			Month AFRIL	Day Year	11:15A M
>	/Medid Examin		4a. Facility Name (If not institution,			4b. City, Town, or L	ocation of Death	FIT I'V of the	4c. County of Death	
			Saint Joseph	Medical C	enter		Towso	n	Balt	imore
	Funeral Director		219.22.5725	. Sex 7. Age ((In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MARCH 2	Year) Col	pplace (State or Foreign intry) RYLA N
	land		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I sh	to	MARYLAND BALT	IMORE	RALTIM	ORE				1 ☐ Yes 2 🗷 No
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	23a c	al D	9244 SMITH	4 AVENUE		21234	+		USA	
92	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural", or Items 23a or 28a-1 show event, I'm Medical Evarrinar must be notified at	y Funeral	11. Marital Status 1 □ Never Married 2 ◯ Married	12. Was Decedent Ev Armed Forces?		Was Decedent of His If Yes, specify Cuban 1☐ Yes 2X No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	, etc.
21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					V V	HITE
15	in 72	Completed	15. Decedent's (Specify only highest)	gra de completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ring most of worki	ing 10	6b. Kind of Business/Ir	ndustry
212	ad within /giene. ier then "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		IEMAKER		<i>f</i>	AT Hom	E
	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, La				18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>yla</u>	should be nd Menta marked imatic ev	To	WILLIAM LAN	GSTON SHE	ELTON	(CALLIE	GERT	RUDE DA	VIDSON
Maryland	2 8 8 9		19a. Informant's Name/Relationship	- /, 1	0 -	ng Address (Street an	d Number or Rura	I Route Number, (City or Town, State, Zi	p Code)
-	is 1 and of Health item 27 other to		HARRY V VESSEY 1 20a. Method of Disposition	AGG /1-1/1584	20b. Place of Dispo			ALTIMOR Date 20	Cc. Location - City or T	21234
Jor	00		1 🗷 Burial 2 □ Cremation 3		cemetery, crei	matory or other place)) A		_	0.00
Baltimore ,	그 든 은 글		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice 		PARKWOO	2. Name and Address		21.09	HARKVILLE APEL OF 1	MARYLAND
Ba	Depa Impo any ir		* Buly ly	Q. 20, 1215	. 1					1D 21234
			23a. Part1. Enter the disease, or co shock, or heart failure. Ust on	mplications that caused th		er the mode of dying,	such as cardiac o	r respiratory arres	t,	Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition		TORY FAI					Onset and Death
	/Medical		resulting in death)	Due to (or as a c		LUME			i i	- WEEKS
	Examiner		Sequentially list conditions,	B RENAL F					6	WEEKS
_	ed isit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or legal)	Due to (or as a o	consequence of):					
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_										
.O. Box	res that the death certifi signed by the attending I be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
Δ.	s that	by Ph	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause given	in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
rds	w requires been sig should be	ed b						1 ☐ Yes	2 No 3 □ Prob	oably 4 Unknown
Records,	has has	Completed						24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
Vital	Physician: Th r this certificate ral director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death		E110 1 1 1 1 3 3	
of <	Physician: r this certific ral director,	P.	1 ☐ Yes 2 🔀 No		2 ER/Outpatien		4 Li Nursing Hon	ne 5 🗆 Residend	ce 6 □Other (Specif	ý)
	ling Afte fune	on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Work?		8d. Describe how	injury occurred	
Division	oftendi death. ctor: A y the fu	licat	2 Accident investigat 3 Suicide 6 Could not	be one Disease their	- At home, farm, str		s 2 No	28f Location (Street	et and Number or Rura	al Pauta Number
<u>S</u>	after after Dire	Certification:	4 Homicide determine	building, etc. (Specify)	set, ractory, omos		City or Town,	State)	ar noute Number,
7	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	edical C	29a. Certifier 1 Certifying 1 (Check only one) 1 Medical Ex	Physician: To the best of raminer: On the basis of examiner and manner stated	camination and/or inv	n occurred at the time, vestigation, in my opin	, date and place, a lion, death occurre	and due to the caused at the time, date	se(s) and manner as s a and place, and due to	tated. the cause(s)
	within To th compl	Me	29b. Signature and litle of certifier	11 1		29c. License r	number	29d	. Date signed (Month,	Day, Year)
	1		· \/M	MILL		D 354	.53	C	1/25/101	/
ı	5		30. Name and address of person wh	completed cause of deat	th (Item 23a) (Type.				1	(
			LINDA BARR M.	7601 OSI		ADSWOT 3	L-MARYLE	AND 212	214	
* ·	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's		sails				

)			1 - For Unpend Item #23	State of M	aryland / Der					ygiene	0001	101	tron 4
		4	Registrar 1. Decedent's Name (First, Middle, Las			eruncat	e or L	Jeath	2. Date of		2001	3. Time of De] L
	Physic		Sharon Lynn Uhl						Month	Day			М
	/Medi Exami		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of	APRII. f Death	22 4c.	2004 County of Dea	9:59A	
7-1			CARROLL HOSPITAL				IMI	NSTER			CARROL	Γ	
7	Funeral Director		5. Social Security Number 6. S	ex 7. Ag ☐ M 2 <u>X</u> F	ge (In yrs. last birthda 42 Yrs.	y) If Under Months	1 Year Days	If Under 2 Hours	Min. 8. Date of 8 (Month,	Birth Day, Year)	9. Bi	thplace (State or Fo	oreign
7			215-88-0189A Usual Residence of Decedent		42				Oct.	1, 19	бі Ма	ry⊥and	
	show	_	10a. State 10b. County		10c. City, Town or	Location						10d. Inside City L	imits
	he Ma 28a-f	ecto	MD Carroll		Sykesvil							1 Tes 2	Ž] No
	with Sa or	Funeral Director	10e. Street and Number 1266 Buckhorn Roa	a a		10f. Zip	784				en of What C	*	
	death	nera	11. Marital Status	12. Was Decedent	Ever in U.S. 13			spanic Orig	in? (Specify Yes or f Puerto Rican, etc.)	1	d Stat		
98	or Ite	y Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X If Yes, Give	No	1 Yes, spec		n, Mexican, Specify:	Puerto Rican, etc.)		Black, Whi		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland vial Hygiene. Ad othar than "natural", or items 23a or 28a-f show avant, the Medical Erial in at institle notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	160 Dec	edent's Usua		1 00			Specify: W		
215	in 72	Completed	(Specify only highest gra		(Giv	e kind of wor DO NOT us	nk done d se retired)	tion fu <i>ring</i> most	of working	16b. Kin	d of Business	/Industry	
21	ad with	Com	12	College (1-401)	JT)	maker				Her	Househ	old	
Ind	be ital	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name (First, Midd	le, Maiden S	Sumame)		
<u> </u>	d 2 should be 1 th and Mental I 7 is markad of traumatic ava	2	Roy C. Case, Sr. 19a. Informant's Name/Relationship (7)	Supp. Brintl	101. 11-	P . A			ret A. Bu				
Ma	and 2 sealth an n 27 is i		Kurt Uhlig	Husba					or Rural Route Num Sykesville			Zip Code)	
re,	of far I		20a. Method of Disposition		20b. Place of Disp	osition (Nan	ne of		Date		ation - City or	Town, State	
Baltimore,	Page nent ant; ff ury or		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Loudon I			$f \mapsto F$	April 27, 2004	Ra1t	imore.	Maryland	1
3alt	permit. Pag Department Important: 1 any injury o		21. Sign sture of Funeral Service Licen	600		Burrie	d Address		uneral Di	rector	s. P.A		
	<u> </u>		28a. Part. Enter the disease, or comp	(an	200	1212 W	. 01	d Lib	erty Road	Winfi	led, M	D 21784 Approximate	
,120,	Physician /Medical Examiner privale pr	ical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c.	e Intoxication a consequence of): a consequence of): a consequence of):	on.						Inferval Betwee	n h
P.O. Box 687	at the death certific by the attending p tached for use as I	Physician/Medic	in the past 12 months? 1 Yes 2 No	4□Pregnant at 9□Unknown	2 Fetal death 3 time of death 5	□Ectopic pre	ecify)			23	3d. Date of del Month	ivery Day Year	
	ires tha signed I I be det	by	Part II. Other significant conditions co	entributing to death be	ut not resulting in the	underlying ca	use giver	n in Part I.		_		the cause of death	- 11
Sor	w require been si should I	etec					·····		-	Yes 2		X	
Division of Vital Records,	The ate ha	e Completed	25. Was case referred to medical					26 Place o	24a. Wa auto peri 1 Yes	opsy ormed? 2 \(\text{No}	death?	topsy findings avail completion of cause 2 No	able of
> \	ding Physician:	ToB	1 37 162 5 140	Hospital: 1 🗌 Inpatie	nt 2 XER/Outpatie	nt 3 DO	Other		ing Home 5 ☐ Res		□Other (Spec	cify)	
on c		ion:	27. Manner of Death 1 □ Natural 5 □ Pending	Found, Day	Year) 28b. Time (Bc. Injury : Work?	?	28d. Describe		occurred		
isic	Attending r death. actor: After	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ★ Could not be	4/22/04	9:00 ury - At home, farm, st	A M		es 2 NΩNo	CLEUZO		Number of De	ral Paula Alumbas	
D	al or A	Certification;	4 Homicide	Found at	c. (Specify)	root, ractory,	Omce		Sykesvill	wn, State)	266 Buck	ral Route Number, thorn Rd.	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	of my knowledge, dea examination and/or inted.	th occurred a evestigation,	it the time	e, date and nion, death	place, and due to the	031180(6) 34	nd manner as lace, and due	stated. to the cause(s)	
	To the to the total	Σ	29b. Signature and title of certifier		Dm.	29c.	License	number		29d. Date :	signed (Month	, Day, Year)	
			Tatule	con-	Tollah	دسم	0.C	.M.E.		APRIL	23,200	04	
			30 Name and address of person the c	Nica-t	SILKM	111 P	enn s	Street	t, Baltimo	ore, M	aryland	1 21201	
J.	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature								

Physici	an	1. Decedent's Name (First, Middle,	, Last)		Dep iant G				2. Date of D		Yea	3. Time of De
/Medic		MYRTIS			u	ILLIAI	N-3		04	23		
Examin	er	4a. Facility Name (If not institution,			00	4b. City, Town,				4c.	County of De	ath
			ADVENT75 6. Sex 7. A			If Under 1 Year			MD	N	lontgo	nery
Funeral		5. Social Security Number 456–58–3299	1 M 2 DNF	ge (In yrs. la 69	i <i>st birtnd</i> a <i>y)</i> Yrs,	Months Days		Min.	Month, D	irth [U —]	.0~195	irthplace (State or F Country) EXAS
Director		Usual Residence of Decedent							oct.o,	1734	T	zaas
show		10a. State 10b. County		10c. City,	Town or Lo	cation				_		10d. Inside City I
E Deli	tor	MD Prince	George's		Adelp	hi						1 X Yes 2
e or 28e-f show be notified at	Director	10e. Street and Number				10f. Zip Code				10g. Citi:	en of What (Country?
23e	<u>a</u>	9200 Edwards W	Vay			2078	3				US	SA
al', or items 23e Exerciner roust	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Decedent of f Yes, specify Cub	Hispanic Or oan, Mexica	igin? (Spe	cify Yes or N Rican, etc.)	0- 1	4. Race - An Black, Wh	nerican Indian,
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	Physici		Decedent's Name (First, Middle James Richard		. =				2. Date of D Month	eath Da	y Year	3. Tim	ne of Death
	/Medic Examir		4e. Fecility Name (If not institution	, give street and num	ber)		4b. City, Town, o	r Location of Death	April		County of Deeth	<u> </u>	
		1		are Hos	pital		Bose	dale		-	Balt	im	ore.
	Funeral		5. Social Security Number 213 18 6051	6. Sex 7 1 □ X M 2 □ F	Age (In yrs. last birtl 83 Y	rs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, D April	irth ay, Year)	9. Birth	place (Sta intry)	ate or Foreign
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	anyland show		10a. State 10b. County		10c. City, Town	or Lo	cation					10d. Inside	e City Limits
	the Ma 28a-f s	ctor	Maryland Balti	more	Mic	dle	e River					1 🗆 Y	Yes 21 No
5	with the	Dire	10e. Street and Number 1219 Shore Rd.		-		10f. Zip Code	220		-	tizen of What Cou	ntry?	
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5.5	within 72 hours after death with the Maryland sne sne than "natural; or items 23s or 28s-f show the Modical Examiner most be notified at	ete	15. Decedent (Specify only highes	's Education it grade completed)	16a. [Give I	ent's Usual Occup- kind of work done	ation during most of world)	king	16b. K	ind of Business/Ir	dustry	
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ر) ک	e filed al Hygid other	Be Completed	17. Father's Name (First, Middle,	Last)			Transfer	18. Mother's Nam	ne (First, Middle				
Aland	should be ind Mental i marked c	To E	William Wright					Annie L	evell				
Na Na	nd 2 shoulth and 27 is m		19a Informant's Name/Relations Marlene Wright					and Number or Ru Baltim				Code)	
ore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation	2 Demoual from St	20b. Place of I	, crem	atory or other plac	(e)	Date		ocation - City or To		
Wraltimore	Page Iment o tant: If jury or		* 4 □ Donation 5 □ Other (S)	pecify)	Holly H	[il]	L Mem. Ga	rdens 4/3	30/2004	Balt	timore, M	Maryl	and
Ball	permit. Page Department of Important: If any injury or ance.		21. Signature of Funeral Service	icensee		\mathbb{B}	Name and Addres	ss of Facility Li Funera Castern A	1 Home	P.A.	. M-J 21	221	
	rine Control		23a Pirt1. Enter the disease, or mock, or heart failure. List	complications that car only one cause on eac	used the death. Do no	t ente	r the mode of dying	g, such as cardiac	or respiratory a	rrest,	, MI. 21	Approxin Interval	nate Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a A50	ration	`	Paeu	moni	a			Onset an	nd Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	D.CC.	. 1		ı			ica qu
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. C105 Due to (or	ras a consequence of	<u>~</u>	Ditti	lie C	OLIT	15			
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Dia	betes.		Meli	tis					
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Box	eath certific attending pl for use as t	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy	2 🗆					23d. Date of delive	ary	
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Division of Vital Records,	i or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physicia in by the funeral director, page 2 should be detached for use as the bur	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Place of	Injury - At home, farm , etc. (Specify)	n, stree	et, factory, office		28f. Location (S City or Tox	Street and vn. State)	d Number or Rura)	I Route No	ımbər,
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	10		30. Name and address of person v	no completed oause	of death (Item 23a) (Ty	уре, Р	rint) (Dr	ive)_		-	-26-(MD 218	77	
	,		Dr. Kamtan A 31. Date filed (Month, Day, Year)	uvering	9000 Fror	141	in Squa	are Ba	ltimo	re l	MD 213	323	27
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DHMH 17 Rev 1/2001

Charles Richard Ward As Patity Name (If not institution, give street and number) 4. Summer 4. Summy View Drive Social Security Number 5. Social Security Number 5. Social Security Number 6. Sign 7/8 Yis Morth 106. City, Town or Location of Death Phoenix Fineral Director Funeral Director F		_	1 - For State Registrar			Cer	tificate d	of Dea	th		Reg. N	<u>200</u>) l ₄	1347
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100. Colory 100. Colory	Director	}		1⊠M 2∐F	78	Yrs.	IVIOITIIS D	iys Hou	is Mili.	Nov.	6, 1	925	Ind	iana
Charles A. Ward Pearl Humphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Mae Ward Spouse 20b. Place of Disposition 10c Burial 2 (Commation 3) Removal from State 4 (Dogston S) Collet (Speech) 21. Signoff of Pierry Sarvice Route) 22 (Signoff of Pierry Sarvice Route) 22 (Signoff of Pierry Sarvice Route) 23c Pint Eller the classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediated cause (Final Idease or round) 105 (Vork Road, Towson, Maryland 21204 23c Pint Eller the classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediated cause (Final Idease or round) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route	ow ow	}			10c. City, To	own or Los	ation		···				10	d. Inside City Lim
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Charles A. Ward Pearl Humphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Mae Ward Spouse 20b. Place of Disposition 10c Burial 2 (Commation 3) Removal from State 4 (Dogston S) Collet (Speech) 21. Signoff of Pierry Sarvice Route) 22 (Signoff of Pierry Sarvice Route) 22 (Signoff of Pierry Sarvice Route) 23c Pint Eller the classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediated cause (Final Idease or round) 105 (Vork Road, Towson, Maryland 21204 23c Pint Eller the classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediated cause (Final Idease or round) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route) 10c Pierry Route (Pierry Route	ed wil	Cou		1	ľ	Manuf	acture:							
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Physician Medical Examiner 23a. Parti. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate cause (Finds and Sullwah) as a consequence of): Sequentially list conditions, and included cause (Finds and Sullwah) as a consequence of): Sequentially list conditions, and included cause (Finds and Sullwah) as a consequence of): Sequentially list conditions, and included cause (Finds and Sullwah) as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pragnancy in the past 12 months? 1 Ves 2 No 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an appropriate of programs and time of death of sequence of the cause of the cau	Pages 1 and the series of the		1 Burial 2 Cremation 3	B □Removal from State	ceme	itery, crem	atory or other	piace)	; U5/U		20c. L			
Physician Medical Examiner The property of th	permit, Departri Importa any inju		21. Signalule of Yuneral Service	2000	1.5-4-1.5	22.	Name and Ad	dress of Fa	cility					•
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The state of the s	ding Phys. h. After this funeral di	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursin												
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	al or Atter s after dea il Director od in by the	Sertifica	3 Suicide 6 Could no	t be 28e. Place of Inju	ry - At home, (Specify)	farm, stre			_	28f. Location City or To	(Street ar own, State	nd Number 9)	or Rural	Route Number,
teto •	he Hospitt n 24 hours he Funera pletely fille	edical	(Check only 2 Medical E)	caminer: On the basis of	examination a	lge, death and/or inv	occurred at the	e time, date ny opinion, (and place, a	and due to the ed at the time	cause(s , date and) and mann d place, and	er as sta d due to t	ted. he cause(s)
29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause Ordeath (Nem 22a) (Type, Print) 29c. License number 39d. Date signed (Month, Day, Ye. 30. Name and address of person who completed cause Ordeath (Nem 22a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Ye. 30. Name and address of person who completed cause Ordeath (Nem 22a) (Type, Print) 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye. 29d. Date signed (Month, Day, Ye.)	To the company of the	Σ	Ma a c	OM cum			0	345	21		29d. Da	te signed (/	Month, D	y, Year)

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) APR 2 8 2004 32. Registrar's Signature

		4	For Stete Registrar	State of Maryland /	Department of H Certificate of L		ental Hygiene Reg. No.	2004 1	3478
	Physicia	_	1. Decedent's Name (First, Middle, Last)	WATTS			2. Date of Death Month Day	Year . Co.	e of Death
>	/Medic Examin		4a. Facility Name (If not institution, give s			Location of Death		County of Death	
			HARBOR HOSPITA	IL CENTER		If Under 24 Hrs.	O. Date of Right	9. Birthplece (Sta	ata or Foreign
	Funeral Director		5. Social Security Number 6. Sex 214 48 1473	M 2 F 7. Age (In yrs. last	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Year)		MD
	2 3	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location			10d. Insid	le City Limits
:	fied at	to	MD N/A	B	ALTIMORE			15%	Ýes 2 □ No
	or 28a	Funeral Director	10e. Street and Number	· Avenue	10f. Zip Code	230	10g. Citiz	zen of What Country?	
	na 23a	eral		12. Was Decedent Ever in U.S.	13. Was Decedent of Hi Il Yes, specify Cuba		cify Yes or No-	14. Race - American India	n,
020	nours arter dearn with the maryland lural', or Itema 23a or 28a-f ahow al Examinat must be multiked at	ρ	1 Never Married 2 Marned 3 Widowed 4 Orvorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	Il Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:		Black, White, etc. Specify: BLACI	<u> </u>
2	2 mm	Completed	15. Decedent's Edu (Specify only highest grade		6a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	turina most of workii	ng 16b. Kir	nd of Business/Industry	
0000-01717	within iene. than the	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	LABOR		(0)	Mirete Pro	chiers
	be tiled ital Hygi d other avent, ti	Be C	17. Father's Name (Firet, Middle, Last)				(First, Middle, Maiden		
y		To	FREDRICK W		9b. Mailing Address (Street a		H ROYT		
Maryland	and 2 should lealth and Mer m 27 is marke her traumatic		19a. Informant's Name/Relationship (Ty	1	2309 Harn		enue Ba	Hinzore M	D2123
ore,	- I 0 2		20a. Method of Disposition 1 Maurial 2 Cremation 3 F	ceme	e of Disposition (Name of etery, crematory or other place	(e)	oate 20c. Lo	cation - City or Town, Stat	te .
saltimore,	0 0		*4 ☐ Donation 5 ☐ Other (Specify)	AKI	BUTUS CEME			LTIMOREIN	415
a D	permit. Pa Departmen Important: any injury 2005.		21. Signature of Furreral Service Licon		VAUGHN (1012CANATO	E FUNERAL	SERVICES BALTIMORE M	0 21220
	Physician /Medical Examiner	k	23a. Part 1. Enter the disease, or complishock, or heart lailure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent). Due to (or as a consequent).	ce of):	1	arrespiratory arrest,	Onset	imate I Between and Death
,00/00	icate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ce of):				
O. BOX O	The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 Ectopic pregnancy	1		23d. Date of delivery Month Day	Year
7	uires that th signed by Id be detacl	þ	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the underlying cause giv	en in Part I.		use contribute to the cause	
Hecords,	ysician: The law require is certificate has been si director, page 2 should b	Completed	Hyperte	nsion	<i>J</i>		24a. Was an autopsy performed?	24b. Were autopsy find prior to completion death? 1 Yes 2 No	ings available of cause of
VIII		Be C	25. Was case referred to medical examiner?		7/1		n (Check only one)		
010	Physician: r this certific ral director,	2	1 Pres 2 No 27. Manner of Death		VOutpatient 3 DOA Oth	4 [] Nuising no	me 5 Residence		
on	ading I ith. :: After e funer	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury Wor	rk? Yes 2 □ No		•	
DIVISION	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		28l. Location (Street an City or Town, State	nd Number or Rural Route s)	Number,
	A Hospit 24 hours Funera etely fille	dical (29a. Certifier 1 Grantifying Phy (Check only 2 Madical Exam	sician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death occurred at the tiren and/or investigation, in my o	me, date and place, opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. d place, and due to the car	use(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. Licens	se number	29d. Da	te signed (Month, Day, Ye	par)
•	1		1/450	elmo	D :	311)4	4 4	127/20	04
	n)	30. Name and address of person who of			4208	Glen Bur	mo.	2106
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur					

JOHN WOOTEN Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 2641Amend & Unpend Item #4a, 25a, 27, 28a - I per me Coll 5/4/04 tas Mental Hygiene Certificate of Death Reg. No.2 DAP Reg. No 2 U 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 17,2004 **Physician** 12:36а м John Calvin Wooten /Medical 4a. Fecility Name (If not institution, give street and symbor)

4a. Fecility Name (If not institution, give street and symbor) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 143 MARKERT STREET ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 54 Months Days Director Sept. 30,1949 Georgia 250-86-2709 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other treumstic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Directo Maryland Anne Arundel <u>Annapolis</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 United States 143 Market Street death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. Is markad other than "natural" or It≊ 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ U.S. Naval Academy English Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby Lamb Thomas Wooten ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health an Suzanne Wooten / Spouse 143 Market Street Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 tment of It 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or 4/23/2004 Woodstock, Vermont Riverside Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 1/16che 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Asphyxia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month for in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ate has been signification 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2 No Yes 2□No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6X Other (SpecifyAT SCENE 1 X Yes 2 □ No P 2 this 28a. Date of Injury For(1/01th, Day Year) 4/17/04 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: Subject found with plastic bag over After 1 Natural after death. investigation 1 Yes 2 X No head 2XXAccident 6 Could not be determined Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 143 Market Street Annapolis, Anne Artifice County, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Found: Residence 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai 29a. Certifier and manner stated within 2 To the the 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 0 APRIL 17,2004 OCME: cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 111 Penn Street, Baltimore, Maryland 21201 HOGAT

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 2 8 2004

ORIGINAL

32. Registrar's Signature

			State of Maryland / Department of Health and N	Mental Hygier	ne 2001. 121.00
			For State of Waryland / Department of Health and Waryland / Department / Dep	Reg. 1	No. 2004 3480
	Physici /Medic		Carlton E. Walker	Month C	Day - 2004 15:55 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death April 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		4c. County of Death
	Funeral Director		5. Social Security Number (6. Sex) 7. Age (In r.f. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8 Date of Birth (Month, Day, Yea	9. Birthplace (State of Foreign
	show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	death with the Maryland rms 23e or 28a-f show r runt be netfling at	ector	MD N/A Baltimore	1.0	1 ☐ Yes 2 ☐ No
	th with the 23e or 2	Funeral Director	3205 Dorchester RD. 101. Zip Code 21215	109.6	Citizen of What Country?
12	er deat	unera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
980	ours aft	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Specify: Black
72-5-1	filed within 72 hours atter Hygiene. ther than "naturel", or Ite int, Ite Medical Exemite	Completed	15. Decedent's Education (Specify only highest grade completed) [Secify only highest grade completed] [Secify only highest grade completed] [Secify only highest grade completed]	king	Kind of Business/Industry
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land	culd be file I Mental Hy barked oth	To Be	7. Father's Name (First, Middle, Last) 18. Mother's Nam 18. Mother's Nam 18. Mother's Nam	e (First, Middle, Meidl 14 Poar	SON
Mary	2 sho and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur 3205 Dorchester	al Route Number City	y or Town, State, Zip Code)
Sre,	es 1 and of Health f item 27 r other t			Date 20c	Location - City or Town, State
Time State	Pag ment ant: I		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service I cense 22. Name and Address of Facility,	1-04	insdowne, mb
Ball	permit Depart Import any in		Sary P. March Fly 5	370 Fredhi	Hen Pass Balto, mo
			23a. Pen 1. East the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease of condition resulting in death) a. Due to (or as a consequence of):		Jrs.
	Examiner	_	Sequentially list conditions, b. Pneumonia	······································	lwk.
	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
760,	te be executed ysician and ie burial-transit	cai Exa	resulting in death) Last Due to (or as a consequence of):		
68			d.		
Division of Vital Records, P.O. Box	death certificat e attending phy of for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.0	that the de ed by the a detached	Phys	9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown	23e. Did tobacci	o use contribute to the cause of death?
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ion	Attending I death. ctor: After y the funer	ation	1 ☑Natural 5 ☐ Pending (Month, Ďaý Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	200. 00001100 11011 111	jury occurred
Divis	l or Atte after de Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
M	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause red at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
-	To the To the	Me	29b. Signature and title of certifier 29c. License number	· ·	Date signed (Month, Day, Year)
	5		Ophical Completed cause of death (Item 23a) (Type, Print)	t H7	pril 27th 2004
_			CHARU MEHTA, MD 601, South charles Street	it, Balti	more, MD 21230
	Sta Registi		APR 2 8 2004 Server Signature		

			For State Registrar	State of Maryland / E	Department of Health an Certificate of Death		ene No.2004 348
<u>}</u>	Physici /Medic Examir Funeral	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s 5. Social Security Number 1.00	Klin St. Apt. 5	Ab. City, Town, or Location of D R Baltimore thday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth Min. (Month, Day, Y	3. Time of Death 3. 45 P M 4c. County of Death N A 9. Birthplace (State or Foreign Country)
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itama 23e or 28e-1 show any injury or other traumatic event, the Macical Examiner must be multiled at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County ND 10e. Street and Number 3000 W. Frank 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest gradity only hi	10c. City, Town Baltin 12. Was Decedent Ever in U.S. Armed Forces? 1 Fres. 2 No If Yes, Give Year or Dates: cation completed) College (1-4or 5+) 16a. College (1-4or 5+) American 19b College (1-4or 5+) Completed 20b. Place or cemeter Commet	10f. Zip Code 2/829 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 □ Yes 2 □ No Specify: Decedent's Usual Occupation (Give kind of work done during most of life. Do NOT use retired) 11 □ + Q Y POICE 18. Mother's Mariling Address (Street and Number of Company) 10 □ Olde Green 11 □ Specify: 12. Name and Address of Facility 13 □ Address of Facility 14 □ Yes 2 □ Name and Address of Facility 15 □ Name The Company of Specify: 16 □ Pore St. VA □ House Specify: 17 □ Pore St. VA □ House Specify: 18 □ Pore St. VA □ House Specify: 19 □ Pore St. VA □ House Specify: 10 □ Pore St. VA □ House Specify: 10 □ Pore St. VA □ House Specify: 11 □ Yes 2 □ No Specify: 12 □ Name and Address of Facility 13 □ No Specify: 14 □ Yes 2 □ No Specify: 15 □ No Specify: 16 □ No Specify: 17 □ Yes 2 □ No Specify: 18 □ No Specify: 19 □ No Specify: 10 □ No Specify: 10 □ No Specify: 11 □ Yes 2 □ No Specify: 12 □ No Specify: 13 □ Yes 2 □ No Specify: 14 □ Yes 2 □ No Specify: 16 □ No Specify: 17 □ Yes 2 □ No Specify: 18 □ No Specify: 19 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 11 □ Yes 2 □ No Specify: 12 □ Yes 2 □ No Specify: 13 □ Yes 2 □ No Specify: 14 □ Yes 2 □ No Specify: 16 □ Yes 2 □ No Specify: 17 □ Yes 2 □ No Specify: 18 □ Yes 2 □ No Specify: 19 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 11 □ Yes 2 □ No Specify: 12 □ Yes 2 □ No Specify: 13 □ Yes 2 □ No Specify: 14 □ Yes 2 □ No Specify: 16 □ Yes 2 □ No Specify: 17 □ Yes 2 □ No Specify: 18 □ Yes 2 □ No Specify: 18 □ Yes 2 □ No Specify: 19 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □ No Specify: 10 □ Yes 2 □	? (Specify Yes or No- uerto Rican, etc.) Name (First, Middle, Ma On Adams or Rural Royle Number, Co ICh Cir. Fire Date 20 28-04 Ou	10d. Inside City Limits 1 Pres 2 No 1. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: Black Sb. Kind of Business/Industry Vaug Academy Inden Sumame) City or Town, State, Zip Code) City or Town, State, Zip Code) City or Town, State, Zip Code) City or Town, State, Zip Code) City or Town, State, Zip Code) City or Town, State, Zip Code) City or Town, State, Zip Code) City or Town, State, Zip Code) City or Town, State, Zip Code) City or Town, State, Zip Code)
760,	Physician be executed attending physician and attending physician and for use as the burial-transit	ical Examiner	23a. Park. Errier the disease, or complishock or heart failure. List only or immediate Zause (Final disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Carry a Due to (or as a consequence Lyper Linds	Infarction of: otery discase	rdiac or respiratory arrest	t. Approximate Interval Between Onset and Death
Vital Records, P.O. Box 68	aw requires that the d s been signed by the 2 should be detached	Completed by Physician/Medi	235. Was decement pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown Intributing to death but not resulting in	5 Other (specify)		23d. Date of delivery Month Day Year cco use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Unknown} \) 24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital R	Attending Physician: The ordeath. ector: After this certificate by the funeral director. pag	Certification: To Be Cor	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		utpatient 3 DOA Other: 4 Nursii Time of Injury M 1 Yes 2 No	1 ☐ Yes 2 ☑ Death (Check only one) ng Home 5 ☐ Residence 28d. Describe how	ce 6 Other (Specify) rinjury occurred et and Number or Rural Route Number,
	To the Hospital or within 24 hours after to the Funeral Directions completely filled in	Medical C	29b. Signature and title of certifier 29b. Name and address of person who c	ompleted cause of death (Item 23a)	e, death occurred at the time, date and production in my opinion, death of the strength of the	occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s) d. Date signed (Month, Day, Year) 4/26/04 Ballim Mo
4	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2. 8. 2004	32. Registrar's Signature	/		

DOS 04-2816 Hurley Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_			For State Registrar AMEND TIEM #2	/ State of Maryland /0 b PFR FH (831 5/04	Department of Health and Open Control of Death	Mental Hygie Reg.	m 201 1010 5
	Physic	an	1. Decedent's Name (First, Middle, Las	1, 1, 1		2. Date of Death Month	Day Year 3. Time of Death
1	/Medi Examii		4a. Facility Name (If not institution, give	WIIIGMS a street and number)	4b. City, Town, or Location of Deat	April 25,	2004 636 a M
1			1815 Lemmon Stre	et	Baltimore		NA
	Funeral Director		5 Social Security Number 6. Sr 3/3-02-206/ 1 Usual Residence of Decedent	7. Age (In yrs. last)	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye	9. Birthplace (State or Foreign Mary Land
	yland Now		10a. State 10b. County		own or Location		10d. Inside City Limits
	Ba-f sl	ctor	MD NA	Balt	imore		1 No res 2 □ No
	s atter death with the Marylar, or Items 23a or 28a-f show antirethest at the notified at	Funeral Director	960 N. Franklin	ntown Rd.	10f. Zip Code 21210	US	Citizen of What Country?
920	within 72 hours atter death with the Maryland ene. then "naturel", or items 23e or 28e-f show he M. dical Ex.: uriet". sist be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
5-0	72 hours "naturel",	leted	15. Decedent's Ed (Specify only highest grad	ucation 16 de completed)	a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16b	. Kind of Business/Industry
212	be filed withir tal Hygiene. d other then event, the W.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	andscaper		andscaping
Maryland 21215-0036		To Be (17 Father's Name (First, Middle, Last) Hurley William	1S	18. Mother's Nan	ne (First, Middle, Maid Dabb	den Surname)
	d 2 sho th and 7 Is m traum		19a. Informant's Name/Relationship (7	s-mother s	960 N. Franklinton	val Route Number, Cit	ty or Town, State, Zip Code) 3 alto, MD 21216
Baltimore,	int of in		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	of Dismiliar Marine (Vaco) Armel Cemetery 5-1	Date IA	NSTUNE, PD own, State
Balt	permit. Pa Departmer Important any injury once.		21. Signature of uneral Service Licen	me	22. Name and Address of Facility	270 Fredhi	Hon Pass Balto, mo
			23a. Pav1. Enter the disease, or composhook, or heart failure. List only of	lications that caused the death. Done cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease of condition resulting in death)	a. Otherosclett	of Cardiovas	inter d	SCoS C Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	t. Due to (or as a consequence	e of):		
Ć.	executed in and ial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence	e of):		
68760,	tificate be executed ig physician and as the burial-transit	edical		d			
.O. Box	death cer e attendin d tor use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 □Ectopic pregnancy 5 □ Other (<i>specify</i>)		23d. Date of delivery Month Day Year
Δ.	res ign	by	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably Winknown
Records,	e taw has b	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Vital	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical		26. Place of Deal	1 Yes 2 ☐ I	
of V	shys this al di	ဥ	1 X 195 2 100	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 Mother (Specify) at scene
	ling After lune	atlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of 1 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred
Division	el or Attendi s atter death. I Director: A d in by the t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, the building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
1/1	To the Happitel or Attenc within 24 hours atter death To the Funeral Director: completely tilled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	ie, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To th To th comp	ž	29b. Signature and title of certifier	: D 11	29c. License number	29d. [Date signed (Month, Day, Year)
•			Hatruc Wi	onice toll	OCME OCME	A	pril 25, 2004
	4	П	30. Hame and address of person who co	ompleted cause of death (Item 23a)	111 Penn Street	, Baltimo	re, Maryland 21201
	Sta Registr	te ar	APR 2 8 2004	32. Registrar's Signature	Sparks		

		4	For State Registrar		State of	Marylar		artment of		d Mental Hy	giene	որև	131.83
	Physicia /Medic		1. Decedent's Name (First, Mi						-	2. Date of De Month 4 / 2 5	ath	Year	3. Time of Death 12:14 ^A M
	Examine		4a. Facility Name (If not institu			,			, or Location of D			ty of Death	
			Joseph Rito	_					imore		N/	1	
	Funeral Director		5. Social Security Number 241-62-8777	6. Sex	M 25xF	7. Age (In yrs. 87	Yrs.	Months Day		Ars. 8. Date of Bit (Month, De 10/3	1, 700°) 1, 1917	Cour	place (State or Foreign ntry)
land	Mo ₩	ŀ	Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. Ci	ly, Town or Lo	cation				1	10d. Inside City Limits
Man	a-f sh iffied	tor	Md N	I/A		В	altimo	ore					Yes 2 No
ith the	or 28	Dire	10e. Street and Number					10f. Zip Code)		10g. Citizen of	What Cour	ntry?
eath v	10 23s	era			Aven		6 12 1	212		1/0	USA		:
6 after d	il flygiene. other then "natural", or lieme 23a or 28a-f show vent, the Mudical Examinar must be notified at	Funeral Director	11. Marital Status 1 Never Married 2 N		Armed Ford	ces? 2 □ No				(Specify Yes or No Jerto Rican, etc.))- 14. Ha	ace - Americ ack, White,	etc.
003	ural;	Completed by	3 Widowed 4 Divord		If Yes, Give Year or Dat	tes:		1 □ Yes 2 및 No			Spec	Blac	
15.	n na Audici	piete	(Specify only hig		completed)	15-3	16a, Deced (Give	dent's Usual Occi kind of work don DO NOT use retir	upation le during most of l red)	working	16b. Kind of I	Business/Ind	dustry
212 od with	giene er tha	mo.	Plementary/Secondary (0-12) 7 years	2)	College (1-	4or 5+)		nestic			House	Wif∈	3
Maryland 21215-0036	U TO	Be	17. Father's Name (First, Midd GRAY SPEIGH						18. Mother's I	Name (First, Middle	, Maiden Suma	me)	
aryla should	mark mark	၉	19a. Informant's Name/Relation		oe, Print)		19b. Mailin	a Address (Stree		Rural Route Numb	er. City or Town	n State Zin	Code)
Me and 2	alth a 127 is er trau		Robert Alle	n Wr	ight					e. Balto		2121	
Baltimore,	If Item or oth		20a. Method of Disposition 1 □ Burial 2 □ Crematic	n 3⊟Re	emoval from Si		lace of Dispo	sition (Name of natory or other pl		Date	20c. Location		
2/4 II = 1	utmen utant: njury		* 4 ☐Donation 5 ☐ Other 21. Signature of Fain wal Servi	(Specify)				n/Gard			Wilson		
Ba Ba	Impourant in suny ir s		Mulle	81	(Du	elle	1	Name and Add	berty H	Howell Heights	Balto.	al Ho	me 1 21207
			23a. Part1. Enter the disease shock, or heart failure. L	or complic ist only on	e cause on ead	ch line.	h. Do not enti	er the mode of dy	ying, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	ysician Medical	i	Immediate Cause (Final disease or condition resulting in death)	a.				colon	Cancer				> 1 40
£x	aminer					r as a conseq	uence oi):						
250	sit .	luer	Sequentially list conditions, if any, leading to immediate cause. Enter United by Cause (Disease or injury	1 "		ras a conseq	uence ol):						
), executed	ician and burial-transit	Examiner	that initiated events resulting in death) Last	c.	Due to (or	r as a conseq	uence of):						
ht 8760,				d.									
O \$	ing phies as th	Medi	IF FEMALE:			· · · · · · · · · · · · · · · · · · ·							
Box	attend for us	clan	23b. Was decedent pregnant in the past 12 months?	23		ome of pregna th 2 Peta nt at time of d	Ideath 3	Ectopic pregnant Other (specify)	су		,	ate of deliver	nry Day Year
P.O.	by the tached	Physician/Medical	1 🗆 Yes 2 🗗 No 9 🗆 Unknown		9□ Unknow		Juli 5_	Cirial (Spacify)					
Records, F	engi	2	Part II. Other significant cond	itions cont	tributing to dea	th but not resi	ulting in the ur	derlying cause g	iven in Part I.		obacco use con res 2 🗆 No	ntribute to the	e cause of death? ably 4 Munknown
eco law re	2 5	Completed								24a. Was		Were autor	psy findings available inpletion of cause of
<u> </u>	certificate has rector, page 2									perfo 1 Yes	rmed?	death?	2(1 No
of Vital	s certif lirecto	lo Be	25. Was case referred to medi examiner? 1 Yes 2 No		ospital:	nationt 2	ER/Outpatient	30 004 0		Peath <i>Check onl o</i> Home 5☐ Resid			il and a
	After this funeral dir		27. Manner of Death 1 Natural 5 ☐ Pen	din a	28a. Date of (Month,		28b. Time of Injury	28c. Inju	ury at	28d. Describe h	now injury occur	rred	Hospice
Division to Attending	ctor: Al	catic		stigation				M 1	Yes 2 □ No				
DIV	I Direct	Certification:	4 Homicide dete	mined	building	i injury - At no j, etc. <i>(Specif</i>)	me, larm, stre	et, lactory, office		281. Location (S City or Tox	Street and Numb m, State)	oer or Rural	Route Number,
HOSPH AL		edical (29a. Certifier 1 Certification (Check only one)	ying Physi al Examin	cian: To the ber: On the bas	is or examinat	wledge, death tion and/or inv	occurred at the t estigation, in my	time, date and pla opinion, death oc	ice, and due to the courred at the time,	cause(s) and madate and place,	anner as sta and due to	ited. the cause(s)
To 2	Tot		29b. Signature and title of certi	fier					se number		29d. Date signe		
		-	2080)	D	and the disc	al de-th //-	00-1 7	D	24170		April	26, 20	204
4	2		30. Name and address of persons	iche	y Hosp	. (23a) (Type, F). Entar	NSt. B	baltimore	MD Z	21201	
	State Registra	_	31. Date filed (Month, Day, Yea			gistrar's Signa	ture &	Spark					

			1 - For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth and N Death	lental Hy	giene 2	004	13481
	Physic /Medi	300	Decedent's Name (First, Middle, Myra C.	Last) West			<u> </u>		2. Date of De Month April	Day 23,	Year 2004	3. Time of Death 7:00PM
	Exami		4a. Facility Name (If not institution, Washington Adv	give street and nu				Location of Death		4c. Cour	nty of Death	
	Funeral Director		5. Social Security Number 577-52-7418	6. Sex 1 □ M 2 🌠 F	7. Age (In yrs. 67	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da June 16	th ly, Yea <i>r)</i>	9. Birthp Coun	lace (State or Foreign htry) h Carolina
	e Maryland 3a-f show tiffed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montg	omery	10c. Ci	ity, Town or La	Silver	Spring				0d. Inside City Limits 1 ☐ Yes 2 🌠 No
	3a or 28	I Dire	10e. Street and Number 1400 Fenwick La:	ne #214			10f. Zip Code	910		10g. Citizen o	What Coun	*
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ira Medical Examination to invitibut at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Armed Fo	2 X No ⁄e		Was Decedent of Hi If Yes, specify Cubai 1 ☐ Yes 2 🕅 No		ecify Yes or No Rican, etc.)	- 14. R	ace - Americ lack, White,	an Indian,
21215-0036	within 72 horiene. Than "natural in a Medical is	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 1 2	Education grade completed) College (1	-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, Homemaker	luring most of work)	ing	16b. Kind of	Business/Ind	·
Maryland 2	uld be fited Aental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, L Jimmy	cunningh	am	<u> </u>	Tromema Re I	18. Mother's Name	e (First, Middle, Mae		ıme)	<u> </u>
Mary	d 2 shouth and had the material trauma	1	19a. Informant's Name/Relationshi		a		ng Address (Street a					
Baltimore,	Pages 1 an lent of Hea! nt; If item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.	3 ☐Removal from	20b. F	Place of Dispo cemetery, cren	Fenwick L sition (Name of natory or other place e Cremato) April	27	r Sprin 20c.Location Beltsv	- City or To	wn, State
Balti	permit. Departm Importa any inju		21. Signature of Funarat Strings 1	mann	_ M003	382 R 9	Name and Address app Funer 33 Gist A	al and Co	remation ver Spri	n Servi ing, MD	ces	
8760,	Physician // Medical bulsal-transit supported the prival-transit supported the prival function of the prival funct	dical Examiner	shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease of Injury that initiated events resulting in death) Last	a. Due to (or as a consequence or a consequence or a consequence or a consequence or a consequenc	uence of):	ecteremie					Interval Between Onset and Death
O. Box 68	death certifi e attending i id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		inth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregnancy Other (specify)				ate of deliver	y Day Year
ecords, P.	The law requires that the site has been signed by the sage 2 should be detached.	by	Part II. Other significant condition	s contributing to de	eath but not resi	ulting in the un	derlying cause give	n in Part I.		bacco use cor es 2 \(\square\$ No	ntribute to the	e cause of death?
Vital Reco		Completed	Kenal turnt	fictener	Hq	pertens	im Card	rovasculer	perfor	sy	prior to com death?	sy findings available ipletion of cause of
ō	ding Phys h. After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 20 No 27. Manner of Death Natural 5 Pending investiga	28a. Date of (Monti		ER/Outpatient 28b. Time of Injury	3 DOA Other	4 🗆 Nursing Hor		ence 6 🗆 Ot		
DIVISION	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place	of Injury - At ho g, etc. (Specify	ome, farm, stre	eet, factory, office	-	28f. Location (S City or Town	treet and Num. n, State)	ber or Rural	Route Number,
1	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	edical	one)	Physician: To the aminer: On the ba and mann	sis oi examina	wledge, death tion and/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre	and due to the c ed at the time, d	ause(s) and m late and place,	anner as sta and due to t	ted. the cause(s)
/	V With	Σ	29b. Signature and title of central and the signature and title of central and the signature and the s	sen m	V		29c. License	0362	2	Ped. Date signe Amil	24,	2004
)		30. Name and address of person when the second seco	SONMD	of death (Item	5 Delc	restRoid	Hyats	alle, M	P 20	182	
	Sta Registr	_	APR 2 8 20	0.	esta o orgina	6	South 1	· ·				

				1 - For Amend Ite State Registrar			,683	1,05/2	28/04(19) Ce	rtificate	of E	ealth a Death	nd IV	lental Hy	gier Reg. I		04	13	85
		Physici	ian	Decedent's Name (First, Min										2. Date of Do Month		Day	Year	3. Time	
	1	/Medi		Beatrice Mari			ımborl			4h Cihi Ta		1 - 4-4: 4	Death	April				0758	M
		Examir	ner	4a Facility Name (If not institu Gilchrist Center St. Joseph Ho	for	Hospice	Can	9		4b. City, To		cocation of				ac.Count Balti	y of Death more		
		Funeral		5. Social Security Number	6. S	iex			last birthday)	If Under 1	/ear	If Under 2	4 Hrs.	8. Date of Bi (Month, D				place (State ntry)	or Foreign
		Director		214-26-4441	1	□M 211 F			79 Yrs.	Months D	ays	Hours	Min.	Apr 2,	19	25	PA	ntry)	
		and w		Usual Residence of Decedent 10a. State 10b. Cour	nty			10c. Cit	y, Town or Lo	cation								10d. Inside (City Limite
		Maryl f aho	to	MD N/A					timore										s 2 No
		r 28a	Director	10e. Street and Number					- CIMOI C	10f. Zip Co	od <i>e</i>				10g. (Citizen of	What Cou	ntry?	
		th witi	alD	6217 York Road	Ė					21212	2				Un.	ited	State	es	
		is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was 12 te marked other than "natural", or Items 23s or 28s-f ahow other traumatic event, it's Madical Exertinal must be notified at	Funeral	11. Marital Status		12. Was Dec	orces?	_	S. 13.	Was Deceden	t of His Cuban	panic Origi	in? (Spe	ecify Yes or No Rican, etc.))-		ce - Ameri	can Indian,	
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	Baltimore, Maryland 21215-0036	tural		15. Deced			oates:		16a Decer	lent's Usual C)ccupat	tion			105		Whit∈ usin <i>e</i> ss/In		
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	nd	be file tal Hy d oth	Be	17. Father's Name (First, Midd								18. Mother	s Name	(First, Middle	, Maide	en Sumar	ne)		
	yla	ould Men	2	Vincent Charl										nerine		<u> </u>			
	Mar	12 sh h and 7 la m traum		19a. Informant's Name/Relatio										I Route Numb				Code)	
	ė,	1 and Healt em 2	1 3	Kathleen France	ces	ward/Da	augn	20b. P	lace of Dispo	sition (Name o	of.			el Air,	_			own, State	-
	nor	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other			State	C	emetery, cren	natory`or othe	r place	1	Α	pr 26					
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	B	Depariment of the control of the con		Ha	lel		me	-0989	<i>y</i> (remati	on	and F	une	ral Alt s Drive	err	nativ	es	MD	
				23a. Part1. Enter the disease, shock, or heart failure. L	or comp	plications that	caused	the death	. Do not ente	or the mode of	f dying,	such as ca	ardiac o	r respiratory a	rrest,	ратст	more,	Approxima	te
		Pnysician	0)	Immediate Cause (Final disease or condition	ist offiny t				- 265	truct	·	. Lu	AC I	Disen.	18			Interval Be Onset and	Death
		/Medical		resulting in death)				consequ					7					gen	
		Examiner		Sequentially list conditions,		b													
100		ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to	(or as a	consequ	ience of):										
3		ate be executed hysician and the burial-transit	xan	that initiated events resulting in death) Last		c. Due to	(or as a	consequ	ience of):		_				-		_		 -
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	89	ifficate g phy as the	edic		_	. u.		-											
7	ŏ	leath certifica attending ph I for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, out				Earaillá sissa						23d. Da	te of delive	ery	
0	. B	0 0 2	sicla	in the past 12 months? 1 ☐ Yes 2 ☑ No		4☐ Pregr	nant at t			Ectopic pregn Other (specifi						Mo	nth	Day	Year
7	P.0	at the	Phys	9 🗆 Unknown				4.14				_		1					
10	S,			Part II. Other significant condi	mons co	ery di			Iting in the un	derlying cause	a given	in Part I.						e cause of c	
-	O.C.		eted	1 1	1 1 1 -	/	^							124	res a	2 🗆 No	3 ☐ Prob	ably 4 □I	Unknown
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B	of	유 부 la	\vdash	27. Manner of Death		28a. Date (Mon			ER/Outpatient 28b. Time of		Injury a Work?	_4 ∐ Nursi	ing Horr	ne 5 Resid	lence low init	6 XOth	er (Specify ed) Hosp	0100
A	ion		atlo	1 XNatural 5 ☐ Pend 2 ☐ Accident inves	ting stigation		th, Day	Year)	Injury			s 2 No			•	,			
1	Division	er des recto by th	Certification;	3 Suicide 6 Coul	d not be mined	28e. Place	of Inju	y - At hor (Specify)	me, farm, stre	et, factory, off	ice		2	8f. Location (5 City or Tox	Street a	nd Numb	er or Rura	Route Num	nber.
Q	ā	spital or A hours after neral Direc / filled in by				Januar	.,	(Opcomy)						City of Ton	m, Stat	(0)			
ğ	11	2325	edical	29a. Certifier 1 ☐ Certify (Check only one) 2 ☐ Medical	ring Phy al Exam	ysician: To the	asis of 6	examınatı	vledge, death on and/or inv	occurred at the	e time ny opir	, date and p nion, death	olace, a	nd due to the d d at the time,	cause(s	s) and ma	nner as sta	ated. the cause(s	s)
3	1	To the within 2 To the complet	Med	29b. Signature and title of certif		and mani	iei stat	eu.		29c. Lic								Day, Year)	
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		0	1	30. Name and address of person	n ho c	completed ca	of de	ath (Item	23a) (Type. F	leint)					,	-	. (
		0		W.A. Riley	-	BMC	670	1 1	1. Chon	les St.	13	alb.	md	21208	-				
		Sta		31. Date filed (Month, Day, Yea		32. R	egistrar	's Signati	yre /		_								
		Registra	ar	APR 2 8 200	4	Level	Same of the same	67	Ac	an Karl									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🛭 🗓 🗓 1 - For State Ragistrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ૢ૱ઽ Williams 2004 Hori 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death de tartord If Under 1 Year | If Under 24 Hrs. WISING Home Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign
 Country) Days 1 ■ M 2 F Months 218-10-809 Mari Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Har 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced white. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ales Manager 12. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 🗀 e) 2167 8. 4307 Webster Lapidum Kd. Havredebrace MO
sposition (Name of Date 20c. Location - City or Town, State -daug-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 Removal from State woodkwn Cenetery 4-27-04 Paltimore, MD • 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FOREST HILL, MD 21050. 21. Signature of Funeral Service Licensee CHAPEL-BEL AIR, 3 NEWPORT DR. EVAUSFUNERAL Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRA INSUFFICIENCY ween Pul MONARY DIS. HROW C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene Important: If item 27 is marked other than "na any injury or other traumatic event, The Madis 2005.

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner use as the burial-transit this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trar Physician/Medical Completed by

Be

Certification; To

Medical

After

0

filled in by the within 24 hours after death To the Funeral Director:

The law requires that the death certificate be executed

Villiams, Dorthy

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death

4 Pregnant at time of death 9 Unknown

3 DEctopic pregnancy 5 Other (specify)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

FAILURE

24a. Was an autopsy performs

formed? 2/20 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Tyes

25. Was case referred to medical 1 ☐ Yes 2 No

5 Pending

investigation

6 Could not be determined

S,

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

LETICIA

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 | Homicide

1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 28 2004

29b. Signature and title of certifier

GALVEZ 32. Registrar's Signature

S. UNION ANG. HAURE BEGRACE

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11 200 /Medical give street and nymber) 4b. City, Town, or Location of Death 4c. County of Deat (If not institution Examiner enter '/e Thervil If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreig 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Min Days 906 218 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or Itams 23a or 28e-f show other traumatic avent. The Medical Examiner must be notified at 1 ☐ Yes Z uther Completed by Funeral Director 10g. Citizen of What Country? 21093 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status 1 ☐ Yes 20 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Widowed 4 ☐ Divorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Tome 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 mber or Rural Rqute Number, City/or 19b. Mailing Address (Street and Ny 19a. Informant's (Daughter Department of Health ar importent: If itsm 27 Is any injury or other trauonce. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Evans tuneral Cha 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License ase, or complicat his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres Immediate Cause (Final disease or condition resulting in death) inhurn **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner To tha Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 □ Yes 2 ☑ No esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ŏ Month Day Year 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2D No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) safter dea... 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie M ampleted cause of death (Item 23a) (Type, Print) 38 Lett leman Iller 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Maryland		artment of F			giene leg. No. 2	nnl	131.8
		Decedent's Name (First, Middle, Las	it)				2. Date of Dea	th		3. Time of Death
Physic		Irvin	Williams				April	Day	ZCO4	5:15 p. M
/Medi Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	<u> </u>		nly of Death	
		1321 N. Milton AV	Έ			MORE		1/		
Funeral Director		5. Social Security Number 6. Se		st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day May 27,	, Year)	9. Birthp Cour	place (State or Foreign otry)
pu *		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	antion		- / - /		1.	Od Jacida City Limita
laryla ahon	5	11/2		Himo					'	0d. Inside City Limits Yes 2 □ No
the M	Director	10e. Street and Number	DA	MANNET	2 Z 10f. Zip Code			10g. Citizen o	of Matheway Court	
with a or	ā	1321 N. Milton	J AVE		2121	3		U- 5		itty :
ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		ace - Americ	
after or Ite	Ξ	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 No If Yes, Give				Rican, etc.)		lack, White,	etc.
ral',	1 by	3 Widowed 4 □ Divorced	Year or Dates:		1□Yes 2DKNo	Specify:		Spec	city: BIA	ell
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Madical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	lent's Usual Occup	during most of work	king	16b. Kind of	Business/In	dustry
ad within 72 hours at giene. er than "natural", or ; the Medical Exam	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)		1		,
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d 2 should be file th and Mental Hy ?? is marked oth traumatic event	2	19a. Informant's Name/Relationship (7	_	19b. Mailir	a Address (Street	and Number or Rui	NA U	r. City or Tow	m. State. Zin	Code)
od 2 state at 12 s		CASSANDRA Ubia				AVE BA				,
THEAT OTHER		20a. Method of Disposition	20b. Plac	ce of Dispo	sition (Name of natory or other place		Date	20c. Location	n - City or To	wn, State
85=2		1 Surial 2 Cremation 3 C	Removal from State	Timel	De ma	4/3	8/01	Roth.	week AAN	
mit. Pa partmen portant: injury		21. Signature of Funeral Service Licen	see	22	. Name and Addres	ss of Facility BEA	to Faner	A Hon	16	
Depa Impo		(Tatuas B.	etto			PAROLINE ST				3
4		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death.							Approximate Interval Between
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Examiner		Sequentially list conditions,	b							
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ba e ician buria	calE		Due to (or as a consequen	nce or).						
y s	g		d							
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eath cert attendin	clar	in the past 12 months?	1 Live birth 2 Fetel de	eath 3	Ectopic pregnancy Other (specify)					Day Year
that the ded by the detached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		(4,44,4,7)					
s that ned b		Part II. Other significant conditions co	ontributing to death but not resulti	ing in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use co	intribute to th	e cause of death?
quires on sign	pe pe	Cerebrovascula	accident				1 🗆 Y	s 2 🗆 No	3 ☐ Prob	ably 4 🖭 nknown
he law requires t has been signe age 2 should be o	Completed by						24a. Was a		. Were auto	osy findings available
9 4 9	E O						autops	ned? 220 No	prior to cor death? 1 \(\sum \text{Yes} \)	npletion of cause of
sician: Th certificate irector, pag	0	25. Was case referred to medical				26. Place of Deat			1 🗀 105	2 No
, v 0	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	t 3 DOA Othe		ome 5 Reside		ther (Specifi	·)
ng Ph ter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	8b. Time of Injury	28c. Injury Work		28d. Describe ho			,
andir oath. or: Af	atlo	2 Accident investigation		,,		Yes 2 □ No				
I or Attending Physical death. Director: After this I in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (St City or Town		nber or Rura	l Route Number,
Hospitel or Attending Physicien: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director.		/	1							
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After the completely, filled in by the funeral	edical	Check only 2 Medical Exam	sician: To the best of my knowle iner: On the basis of examination	edge, death n and/or inv	occurred at the time estigation, in my or	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and r ate and place	manner as st	ated. the cause(s)
the the	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License					
T W S		255. Signature and title of certifier		01 %			1	9d. Date sign		
5		Clare		MI	0~0	058893		Aberr	2.2	2004
)		30. Name and address of person who of the Samure R.		3a) (Type, Hopk	ins Hos	prtal	Balt	more.	Mar	yland
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Θ A.	And .	4				
Sta Regist		APR 2 8		e M	Procest &	4				

				artment of Health and Mental Hygi	0
8	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) Anthony Wasielewski	2. Date of Death Month April	23 2004 4:01 PM
	Examination Examination Funeral Director	ner	Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 219-16-3055 78 Yrs.	4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 6, 10)	
	he Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	10d. tnside City Limits 1√2 Yes 2 □ No
	ath with the 23s or 2	ral Dir	10e. Street and Number 3032 Dillon Street	10f. Zip Code 21224	g. Citizen of What Country? USA
900	be filed within 72 hours after death with the Maryland tlat Hygiene. Id other then "natural", or Items 23e or 28e-f show event, the Medical Examiner must be notified at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. □ Was Decedent Ever in U.S. Armed Forces? 14. □ Never in U.S. Armed Forces? 15. □ Vas Decedent Ever in U.S. Armed Forces? 15. □ Vas Decedent Ever in U.S. Armed Forces? 16. □ Vas Decedent Ever in U.S. Armed Forces? 17. □ Vas Decedent Ever in U.S. Armed Forces? 18. □ Vas Decedent Ever in U.S. Armed Forces? 19. □ Vas Decedent Ever in U.S. Armed Forces Ever in U.S. Armed Forces Ever in U.S. Armed Forces Ever in U.S. Armed Forces Ever in U.S. Armed Forces	Nas Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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and		Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M.	aiden Sumame)
lary	and and is m	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rural Route Number,	alek City or Town, State, Zip Code)
re, N	1 an Heali am 2		20a. Method of Disposition 20b. Place of Disposi	sition (Name of Date 2)	ea, Md. 21085
Baltimore,	permit. Pages Department of Important: If it any njury or o once.		3 Signature of Funeral Service Licensee Bayview 21. Signature of Funeral Service Licensee 22	natory or other place)	altimore, Md. i Funeral Home, P
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of Vil	S S D	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient	26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence	re 6 ☐Other (Specify)
ion	nding P uth. r: After 1 e funera	atlon:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 2 Accident investigation 2 Accident	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funarel Director: Atter this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	City or Town, S	•
	na Hospitel 24 hours a na Funaral I	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death 2 Medicel Examiner: On the basis of examination and/or investage.	occurred at the time, date and place, and due to the cause estigation, in my opinion, death occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
•	To tha I	Me	29b. Signature and title of certifier	Res-000 A,	Date signed (Month, Day, Year) oril 23, 2084
_	"		30. Name and address of person who completed cause of death (Item 23a) (Type, P Dr. Christine Lee, 4940 Eastern Avenue		4
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 8 2004	house s	

			1 - For State Registrar	State of Maryland	Depa		t of H	ealth a				0 - 1	13490
7.8			Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death
	Physici /Medi		William K. We	aver, Jr.						Month	Zif	2001	1020M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location o	f Death		4c. Coun	ty of Deeth	
			Union Memorial H				timo					/A	
	Funeral	-5120	5. Social Security Number 6. Sex	14 OF		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthple Counti	oce (State or Foreign
A.	Director		7,7 00 10,0	M 2UF 91	Yrs.					Aug. 27,	1912	Georg	jia
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Mon	f show	to	Maryland N/A	Bal	Ltimo	re							1√ Yes 2 No
ď	288	Director	10e. Street and Number			10f. Zip	Code			10	g. Citizen o	f What Counti	ry?
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900	ms 2	Funerai	h	2. Was Decedent Ever in U.S. Armed Forces?	13.	Was Deced	ent of His	spanic Orig	gin? (Spec	cify Yes or No- lican, etc.)		ace - America	
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Maryland 21215-0036	s should be lifed withing and Menfal Hygiene. Is marked other than aumatic event, the M	2	19a. Informant's Name/Relationship (Ty)		9b. Mailir	a Address				Route Number,		n. State. Zip (Code)
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260°	hysician and //Medical instrument was provided by the private transit was the private of the pri	ical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):	stri	rch	ve y	polr	MONNY	dise		nterval Between Onset and Death
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Records,	been sig should b	ed	consestive c	ArdioMYOPK	Hy					1 ☐ Yes	2 🗆 No	3 ☐ Probab	bly 4 DUnknown
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U 2	h. After th funeral	:uo	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury 28b (Month, Day Year)	. Time of Injury	_ 1	Sc. Injury Work?	at	28	ld. Describe how	injury occu	rred	
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,	" ON		30. Name and address of person who con	neleted cause of death (Item 23a	(Type, I	Print)	721	1.1	Unit	4 ch	2011	- MA	21718
- 10	Sta	20	31. Date filed (Month, Day, Year)	32. Registrar's Signature	I	2	100	N	70	31 1	2011	11-66	2140
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	an	Decedent's Name (First, Middle, REBA	, Lasi/		WEISS		2. Date of Month	D	^{ay} 2004	3. Time of De 6:30 A
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uneral irector		5. Social Security Number 237–12–8356 Usual Residence of Decedent	6. Sex 7. Ag 1	e (In yrs. last birthda)	y) If Under 1 Year Months Days		Min. (Month	Birth Day, Year 11920	9.	Birthplace (State or F Country) N.C.
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ms 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Decedent of	Hispanic Origi	n? (Specify Yes o	r No-		merican Indian,
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- 12 ATTENDED		1. Decedent's Name (First, Middle,	Last)		,	Death	2. Date of Dea		3. Time of Dea
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Exami		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of De	path
		SINAI HOSPITAL 5. Social Security Number	5. Sex 7. Age (In y	and dense brindbades it		ALTIMORE If Under 24 Hrs.			N/A
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show	٦	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Lin
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a or	Funeral Director	3021 FALLSTAFF	DOVD #307		10f. Zip Code	21209		10g. Citizen of What (
ns 23	era	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of His		ifv Yes or No-	14. Race - An	U.S.A.
t of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, It a Medical Examinist must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? d 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 🎇 No	, Mexican, Puerto R Specify:	can, etc.)	Black, Wh	
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			= State Registrar		C	ertificate of	Death	Reg. N	0.2004	13497
	Physici /Medi	_	1. Decedent's Name (First, Middle, La Mar 9 byef	1	ANDER			2. Date of Death Month D Z	6 2004	3. Time of Death Z P · M
>	Examir	No. of	4a. Fecility Name of not institution, giv	e street and number),	4b. City, Town,	or Location of Death	4	c. County of Death	•
			UNION MEM	erial H	cipital		146.2		nla	
	Funeral			Sex 7. A	ge (In yrs. last birthd	Months Days		8. Date of Birth (Month, Day, Yea	9. Birthp	place (State or Foreign
1	Director		220 24 8554		78 Yrs			Month, Day, Yea	1925 /NW	rylans
7	2 A =		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location			1	0d. Inside City Limits
	f sh	ro	Morylon M	3	Rall	Guerre				DITES 2 No
4	288	rec	10e. Street and Number		757.61	10f. Zip Code		10g. C	Citizen of What Cour	ntry?
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9	or its	/Fu	1 Never Married 2 Married	1 Yes 2	LNo	1 ☐ Yes 200 No		,	Specify:	
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121	han .	du	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT USO retin	90)	00	un Hano	
S	ther 1		17. Father's Name (First, Middle, Last	2)	710		18. Mother's Name	(First, Middle, Maide		
and	Mental Darked o	o Be	ALBERT				Marca	i Tau	500	
Maryland	and Mental Hygiene. is marked other than aumatic event, the M	F	19a. Informant's Name/Relationship	Type, Print)	19b. M	ailing Address (Stree	at and Number or Rural	Route Number, City	Lor Town, State, Zip	(Code) 7/108
Ma	ariu 2. s ealth ar n 27 is er trau		Descript Al	/2.	15ht 25	himma	Port Dri	APTEY +	kerulk	Red
re,	of Health item 27 i	200	20a. Method of Disposition	iner por	cometani	sposition (Name of crematory or other pla	aca) / Da	ate 20c.	Location - City or To	iwn, State
9	rages nent of int: If it iry or o		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Speci		Lucyoc	. //	etrin 4/30	1/04 /11	Kincan	md
			21. Signature of Funeral Service Lice		pocio	22. Name and Addi	ress of Facility OM	47412-	HAVYIN	new Home
ñ	Departs Departs Imports any Inj		Deru Ah	42		BALTIME	a Mel 2	12/5		
	hysician /Medical xaminer		a. Part 1 Enter th / Isease, or conshiption of the failure. List only limited the Cause (Final disease or condition resulting in death)	a PHEC	ed the death. Do not line. s a consequence of):	enter the mode of dy	ring, such as cardiac or	respiratory arrest,	2	Approximate Interval Between Onset and Death Weg
	ysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
P.O. Box 687	The Taw requires that the beam certaincate it the has been signed by the attending physic page 2 should be detached for use as the L	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetel death at time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of delive Month	ary Day Year
rds, P	quires ma in signed b uld be det		Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying cause g	iven in Part I.	23e. Did tobacco	ouse contribute to the	1
Records,	nysician: The law require his certificate has been significate has been significated.	Completed						24a. Was an autopsy performed?	prior to cor	psy findings available mpletion of cause of
		0	25. Was case referred to medical				26. Place of Death			
>	rnysician: this certificatal director,	To B	examiner? 1 □ Yes 2 No	Hospital: 1 Sunpat	tient 2 ER/Outpa	atient 3 DOA	ther: 4 Nursing Hom	ne 5 Residence	6 ☐Other (Specify	y)
<u> </u>	ing P		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	jury 28b. Tim ay Year) Inju	ry W	ury at 2 ork? □ Yes 2 □ No	8d. Describe how in	jury occurred	
Division	al or Attendi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not l 4 Homicide determined	289. Place of in	njury - At home, farm atc. <i>(Specify)</i>	, street, factory, office	2	8f. Location (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
:	to the hospital or Attending Pri within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral	edical	29a. Certifying P (Check only one) Certifying P 2 Medical Exa	hysician: To the bes miner: On the basis and manner	of examination and/o	eath occurred at the or investigation, in my	time, date and place, a opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as si nd place, and due to	tated. the cause(s)
)	Mithi To the	Σ	29b. Signature and title of eartifier	hol,	IND		155568		Date signed (Month,	
	X		30. Name and address of person who Union Memo		death (Item 23a) (Ty	pe, Print) Inv 20/Uni	155568 na Kats, sersity	Pajku	ay, Bo	altimore
*	St Regist	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	Ana V.		-		-

			1 - For State Registrar	State of Mary		artment of l		Mental Hy	/giene Reg. No. 2 (101.	131.0
			Decedent's Name (First, Middle, L.)	ast)				2. Date of D	eath	J U 149	3. Time of Death
	Physici: /Medic		SHIKLEY	VIOLETTI	A Ada	PHS		APML	22 2	2004	1112 M
1	Examin		4a. Facility Neme (If not institution, gi		./	,	or Location of Death		-	y of Deeth	
			Hugspurg Luti		SING Hone	,	CHERN		1000	Tibers	
	Funeral Director	0	5. Sodal Security Number 6.	Sex 7. Age (Ir	yrs. last birthday)	Months Days		8. Date of B	irth ey, Year) / /922	Coun	lece (State or Foreigr try) (4/41/20
	pur *		Usual Residence of Decedent 10a. State 10b. County	/ 10	c. City, Town or Lo	ocation			/	11	0d. Inside City Limits
	Aaryla f sho	ō	MA-1	IA	-	Polhwon					1 Nes 2 No
	death with the Maryland ms 23a or 28a-f show from the notified at	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	h with	ai D	2019 HCKER	IN Ave		212	17		US	A	
10		Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \)		Was Decedent of It Yes, specify Cul	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No Rican, etc.)		ce - Americ	etc.
5-0036	hours after tural", or the al Examine	by	Widowed 4 □ Divorced	It Yes, Give Year or Dates:		1 ☐ Yes _2	Specify:		Speci	5 15/	ack
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2	illed v il Hygie other t	O e	57 Grack 17. Father Name (First, Middle, Las		Mocs	e w ie	18. Mother's Nam	ne (First, Middle	e, Maiden Sumai	me)	
Maryland	s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 is marked other than other traumatic event, the M	To Be	CHANES From				LIZA	, , , , , , , , , , , , , , , , , , , ,			
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Stree	t and Number or Ru	ral Route Numi	ber, City or Town	, State, Zip	Code DId T
-	and 2 salth a n 27 i		SHIRTEY HOLLY	/Daughter	3619		IN DNIVE		HUOK		
ore	0 0 - -		20a Method of Disposition Burial 2 Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date F-J8-6	20c. Location	- City or To	wn, Stete
Baltimore	permit. Pag Department Important: I eny injury o		'4 □Donation 5 □ Other (Spec	ify)	RBUTUS	Menari	ess of Facility Mary M	2111 1	HKBUTUS	MA	ry/ min
Bal	Depar Depar Impor		21. Signature of Funeral Service Lie	3 5 6 6	B	19/19 Orc /	ess of Facility	ous L	us reys m	Land.	near
		0	a. Part1 Enter the disease, or co	nplications that caused the	death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory	arrest,	Conc-	Approximate Interval Between
	Physician	-	suck, or heart failure. List on m mediate Cause (Final	-	Tony		1 -				Onset and Death
	/Medical		disease or condition resulting in death)	a. RESPIRA Due to (or as a co		PHLUIC	L			-	
	Examiner		Sequentially list conditions	END STAC	E CHAOT	NC OBST	PUCTIVE	PULMO	NARY 1	DISLAS	E
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89	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the		2	d							
Вох	eath certifi attending I I for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1☐Live birth 2☐		∃Ectopic pregnanc	ev.			ate of delive	•
	deat he att	sicie	in the past 12 months? 1 Yes 2 No	4 Pregnant at time		Other (specify)			M	onth	Day Year
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a	ician: Th certificate ector, pag	e Co	25. Was case referred to medical				OS Piese of Pee		2 No	1 Yes	2 🔁 No
=	Physician: r this certificated rail director,	To B	examiner?	Hospital:	2 ER/Outpatie	nt 3 DOA O	26. Place of Dea ther: 4 Nursing H		idence 6 Otl	ner (Snecify	,
of	g Phy ler thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye					how injury occu		/
io	Attanding rr death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigat	on	,,]Yes 2 □No				
Division of Vital Records,	or Attu after de Directo in by ti	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of Injury building, etc. (5	At home, farm, st Specify)	reet, factory, office			(Street and Num own, State)	ber or Ruma	l Route Number,
٥	pitat o	Ce	20a Cadiliar 1 Cadibulan	Physicians To the best of	ur transilardan idazi	h	·				
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying I (Check only 2 Medical Ex	Physician: To the best of mainer: On the basis of examiner stated	amination and/or ir	n occurred at the tivestigation, in my	opinion, death occur	, and due to the rred at the time	cause(s) and m , date and place,	anner as stand due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signe	ed (Month, L	Dey, Year)
			rallyan &	Lieuce		14	45931		APRIL	26,	2004
	m		30. Name and address of person who Deborah I	o completed cause of death	(Item 23a) (Type	Print)					
						PANILITE	GITTS AVE	WE F	muini	THE I	MD 2120
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature						
Dr	HMH 17 Rev 1/2		APR 2 9 2004	Berwa	19 Ap	actor					
U	17 1167 1/2	.001		,	ORIGIN	1AL					

			State Registrar AMEND ITEM #5 I	State of Maryland /				ene . No. 2001	. 10105
	Dhusisi		Decedent's Name (First, Middle, Last)	1/ : /	примоско от		2. Date of Death Month	Dav Year	3. Time of Death
Lagran.	Physicia /Medic	al	Sallie Ma	y Hller	4. 65. 7		April	26,2000	
	Examin	er	4a. Facility Name (If not institution, give st	h	Be 1+	MOSC		4c. County of Death	
	Funeral Director		5. Secial Security Number 6. Sex	7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	ear) Cou	pplace (State or Foreign untry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits
	Mary a-f sh	tor	MD	Bo	il+: mose	2			1 XYes 2 □ No
	or 28	Director	10e. Street and Number	b .4	10f. Zip Code		10g	. Citizen of What Cou	intry?
	s 23e		4/3 N. Ken W	2. Was Decedent Ever in U.S.	13. Was Decedent of H	2 2 4 dispanic Origin? (Spe	cify Yes or No-	U.S.A.	ican Indian.
980	hours after death with the Maryland turel; or Items 23e or 28e-f show at Examiner must be notified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	an, Mexican, Puerto F	Rican, etc.)	Black, White	
21215-0036	72 hours naturel;	Completed	15. Decedent's Educ (Specify only highest grade		a. Decedent's Usual Occup (Give kind of work done	during most of working		b. Kind of Business/li	ndustry
121	d within 72 ho piene. r then *natur the Madical	jdmo	Elementary/Secondary (0-12)	College (1-4or 5+)	House K			Priva-	+ e
	Hyg Hyg ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name		iden Sumame)	
ylaı		10	Buddy Al	ENWILLE ALLEN		Yans	y ch	avis	
Maryland	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		19a. Informant's Nam Pelationship (Typ Randolph A	Al hou	b. Mailing Address (Street	_		mp Md 2	
	s 1 an if Heal item 2 other		20a. Method of Disposition	20b. Place	of Disposition (Name of	Da	ate 20	c. Location - City or T	own, State
Baltimore	Pages ment of ant: If it ury or o		1 A Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Hol	y Rosary	5-1	-04 C	oundall	K MD.
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	and	y Rosary 22. Name and order Wesley C 2007 E	hay:5 Jr.	Funera	1140211	03/
r			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death. Do	not enter the mode of dyin	ng, such as cardiac or	r respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	PANCREATION Due to (or as a consequence		ER		(5 MON THS
B	Examiner		Sequentially list conditions, b.	Due to (or as a consequence	of):				
	ited insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	3 OI).				
ó	be executed sician and burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequence	e of):				
8760	cate be ohysici the bu	dical	d.						
O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)	<i>t</i>		23d. Date of delive Month	very Day Year
۵.	quires that I n signed by uld be deta	by	Part II. Other significant conditions con	ributing to death but not resulting	in the underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	
of Vital Records,	: The law require cate has been signified to the control of the co	Completed					24a. Was an autopsy performe	prior to c	copsy findings available ompletion of cause of
/ital		BeC	25. Was case referred to medical examiner?		0.00	26. Place of Death	(Check only one)		
of	d is	. To	1 ☐ Yes _2 No	ospital: 1 Inpatient 2 ER/C		4 Nursing Hon	ne Residence 28d. Describe how	ce 6 ☐Other (Specinium occurred	ify)
o	ding th. : After s funer	tlon	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Wor	rk? Yes 2 □ No	od. Boddibo ilow	injury occurred	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	edical (ician: To the best of my knowledger: On the basis of examination a and manner stated.					
	To the within To the comp	×	29b. Signature and title of certifier		29c. Licens			I. Date signed (Month	
			DITWO	MO		5902	Afr	214 28,20	,04
	7		30. Name and address of person who co		(Type, Print)	Val N. Ros	ADMAU D.	ALT, MORE	MD 21231
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	·	[01 - 19]	11.10	-114 -4-1	
D.	Regist	_	APR 2 9 2004	frequent &	Sports				
D)	HMH 17 Rev 1/2	1002							

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death
	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 4 19 2004 12:75 P M
1	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4d. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1 North
	Aaryland I show	o	Usual Residence of Decedent 10a. State
	with the A 3a or 28a-	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2928 GRANTLEY AVENUE 21215 U.S. OF A.
36	n 72 hours after death with the Maryland "natural", or Itema 23a or 28a-f show after Evantiner must be motified at	by Funera	11. Marital Status 1
21215-0036	within ane. than	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALESLADY 16b. Kind of Business/Industry DEPARTMENT STORE
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) LAWRENCE JOHNSON 18. Mother's Name (First, Middle, Maiden Sumame) ALICES GRAVES
Mary	and and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSLYN SAMUEL (DAUGHTER) 1806 RUXTON AVENUE BALTIMORE, MARYLAND21216
Baltimore,	90=5		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Oct. Ocalion City of Dwin State of Disposition (Name of cemetery, crematory or other place) 3
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lines EWIS T. GWYNN 22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393
Service of the last	Physician /Medical Examiner		23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
,092	cate be executed physician and the burial-transit	cal Examine	Sequentially list conditions, if any, leading to immediate cause. Enter this right of the conditions of the cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):
Box 687	eath certificate attending phy ifor use as the	ed	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
o.	that the death ed by the atte detached for	Physician/M	1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
rds, P	w requires that been signed should be del	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
I Records,	aician: The law requires that the death certifica certificate has been signed by the attending ph irector, page 2 should be detached for use as if	Completed	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
Vital	Phyaician: this certific ral director,	o Be (25. Was case referred to medical examiner? 1 Yes 2 No
ion of	ling After fune		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Accident Natural 1 Yes 2 No No No No No No No
Division	al or Attendi s after death. I Director: A id in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To the Comp	W	29b. Signature and little of certifier DL Ang M. D- 30. Name and address of person to completed cause of death (Item 232) (Type Print) BL May 301 St. Faul P Battimore, Ml 202 David Rischerg 31. Date filed (Month, Daf. Year) 32. Registrar's Signature APR 2 9 2004 Security Battimore, Ml 202 David Rischerg
	7		30. Name and address of person to completed cause of death (Item 232) (Type, Print) Battimore, Ma 202 David Rischerg
	Sta Regist	•	31. Date filed (Month, Daf, Year) 32. Registrar's Signature APR 2. 9. 2004 Security & Society April 1. 10 - 10 - 10 - 10 - 10 - 10 - 10 - 1
DH	IMH 17 Rev 1/2	001	- I be a second

Thomas Bowers 04-02830 RPD

Amend Item #1 per ine 631 5/13/04 tas State of Maryland / Department of Health and Mental Hygiene 1- State unpend item#23a,27,PFR ME,G831,5/13/2 selificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Thomas Herbert April 25, Bowers, Jr. 2004 0356 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6045 Old Washington Road Elkridge Howard 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Months Days Hours Min Director 214-64-5503 1957 <u>Maryland</u> 46 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?) is marked other then "naturel", or Items 23e or 28e-f show treumetic event, the Medical Exprending to invitified at 1 ☐ Yes 2 ☐ No Director Elkridge Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6045 Old Washington Road #3 21075 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. e filed within 72 hours after of Hygiene. al Hygiene. I other then "naturel", or Iter 1 Yes 2 No If Aes, Give Year or Dates: 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Millwright 10 Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other treumetic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Herbert Bowers, Sr. Geraldine Barbara Purdy ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen A. Bowers/Wife 6045 Old Washington Road #3 Elkridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 4-27-04 Metro Crematory Inc. Baltimore, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Cremation Society of MD
299 Frederick Koad Ba Inc. Baltimore, MD Edward A. Gregorchik 21228 23a. Part1. Enter the disease, or com well it is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a Wasan autopsy performed? certificate 2 No Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Cther: 2 1 XYes 2 □ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛛 Other (Specify) At Scene this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending 1 □ Yes 2 □ No hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) April 26, 2004 O.C.M.E. redu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MEUDORE MILL

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

2. Registrar's Signature

			1 - For State Registrar	State of Marylan		ment of Health a icate of Death			200	13498
	Physici /Medi		1. Decedent's Name (First, Middle, Las:	F3			1	Date of Death Month Da		
	Examir Funeral Director		4a. Facility Name (If not institution, give	Hay Hosy	last birthday) If	City, Town, or Location of Sulf Him Under 1 Year If Under Days Hours	of Death OFL 24 Hrs. 8. E Min.		. County of D	
	Maryland a-f ahow iffed at	tor	10a. State 10b. County	10c. Cit	BA/HM					10d. Inside City Limits
	ith with the 23a or 28 ast be not	al Director	10e. Street and Number 902 MARIAU	Durce	1	0f. Zip Code 2/2/2	-	1	izen of What	Country?
980	hours after death with the Maryland lural, or frams 23s or 28s-f show at Examilier must be motified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give (Year or Dates:	If Ye	Decedent of Hispanic Oris, specify Cuban, Mexicar Yes 28 No Specify:	igin? (Specify n, Puerto Rica	Yes or No- n, etc.)	14. Race - A Black, W Specify:	
ம்	d within 72 jiene. r then "na rhe Medic	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give kınd life. DO l	s Usual Occupation of work done during mos NOT use retired) CARC	-		ind of Busine	ss/Industry Inoustice
Maryland	be file ital Hyg id othe evant,	To Be C	17. Father's Name (First, Middle, Last) ALBERT W- TA			18. Mothe	er's Name (Fin	st, Middle, Maiden	Sumame)	
-	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		BALBACA ROBINS	in Daughter	612	Marlau D	rive -	Ralhe	x n	101212
Baltimore	Page ent o nt: If ry or		20a. Method of Disposition Surial 2 Cremation 3 F 4 Donation 5 Other (Specify,	Removal from State	Place of Disposition cometery, cremato,	(Name of cry or other place)	51476	my Ou	ocation · City	MILLS ALL FENER MON
Ball	permit. Departmimporta any inju		21. Signature of Fungral Service Liosh	hy	22. Na 52 4	me and Address of Facility O RCS TER	JABUST JABUST	KOND - W	BMS	Fined Wir
180	Physician /Medical Examiner		234 Part. Enter the disease or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	CVD	e mode of dying, such as	cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	be executed icien and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, cleans or injury that initiated events resulting in death) Last	b						
. Box ba	death certifica e attending ph d for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of diego Unknown	I death 3 □Ecto	ppic pregnancy er (specify)			23d. Date of o	delivery Day Year
	ires that signed d be de	by	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the underf	ying cause given in Part I.		23e. Did tobacco u		to the cause of death? Probably 4 □Unknown
		Completed						4a. Was an autopsy performed?	prior t	autopsy findings available o completion of cause of ? es 2 \(\sum \text{No}\)
Y VIE	Physician: this certific ral director,	To Be	JE 165 2 140	Hospital: 1 ☐ Inpatient 2 ₽		□ DOA Other: 4 □ Nu	of Death (Che	eck only one) 5 ☐ Residence (3 ∐Other (S≱	pecify)
DIVISION	Attending Price death.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			Describe how injur	y occurred	
2	i ji fe		4 Homicide determined	28e. Place of Injury · At he building, etc. (Specify	W		6	ity or Town, State		Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wiedge, death occ tion and/or investig	urred at the time, date and gation, in my opinion, deat	d place, and d th occurred at	ue to the cause(s) the time, date and	and manner place, and d	as stated. ue to the cause(s)
•	To the sound	Σ	29b. Signature and title of certifier	he.		29c. License number	1230			onth, Day, Year)
	"			SHA SHIDHA	FRAN .	GOOD SF	AMAR	ITAN H	OSPITA	25 2004 -1, MD21239
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 9 2004	32. Registrar's Signa	ture La	d				

DHMH 17 Rev 1/2001

ORIGINAL

			1 = For State Registrar	State of Man		artment rtificate				giene Reg. No. 20	04 13490	
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month			
ر تعشیع	/Medic		Robert Herman Baze 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				04 10:20 PM	
	Examir	ıer	Sinai Hospital of		11.4.4.7			e Ci		4c. County o		
	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1	Year I	If Under 24 H			J/A 9. Birthplace (State or Foreign	
Ľ	Director		241-42-7421	M 2□F 7	1 Yrs.	Months [Days	Hours Mi	n. (Month, Da 12-1	th y, Year) 4-1932	Birthplace (State or Foreign Country) NC	
	D		Usual Residence of Decedent 10a. State 10b. County	14/	Dc. City, Town or Lo							
	shov	ī									10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	28e-1	Director	Md N/A 10e. Street and Number		Baltim	lore 10f. Zip Co	odo			40- 05		
	With With	Funeral Di					21207				hat Country?	
	death		11. Marital Status 1 Never Married 2 Married 3 Was Decedent Ever in Armed Forces? 1 Yes 2 No lift Pes, Give Year or Dates:					(Specify Yes or No	USA 14. Race	- American Indian,		
9	after or Ite	Fur				lf Yes, specify Cuban, Mexican, Puèrto F 1 □ Yes 2 □Mo			erto Rican, etc.)		Black, White, etc.	
5-0036	within 72 hours after death with the Marylan ane. Then 'neturel', or Items 23e or 28e-1 show Medical Evaniner must be notified at	d by				1 Yes 2L	™ 00 :	Specify:		Specify: Black		
7	"nett	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual C kind of work of DO NOT use i	occupation done duri	on ing most of w	rorking	16b. Kind of Bus	siness/Industry	
121	be filed that Hygie od other event, the	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		echni				D 111		
2 2		To Be Co	17. Father's Name (First, Middle, Last)			ecimi			ame (First, Middle,		ore City	
<u>a</u>			Walter Baze						ammie Pi		,	
Maryland	short A		19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (S	treet and	l Number or I	Pural Poute Numbe	r, City or Town, S	State, Zip Code)	
	and 2 ealth a n 27 is	8	Si Bettve Katrina W	ster-in-	law 481	5 W. 1	Fore	est Pa	ark Ave.	Balt	o.,Md 21207	
o <u>re</u>	• · = =		Bettye Katrina W 20a. Method of Disposition 1x Burial 2 Cremation 3 Re	movel from State	20b. Place of Dispo cometery, crei	sition (Name matory or othe	of r place)		Date	20c. Location - C	City or Town, State	
Ē	Pages tment of tent: If it jury or o	-	*4 □ Donation 5 □ Other (Specify)	2	Garriso	n Fore	est	03	-06-04	wings	Mills, MD	
Baltimore,	permit. Pag Department Importent: eny injury c		21. Signature of Funerat Service Licenses	160MA	1100	Name and A			Howell E	uneral	Home	
			23a Part 1 Enter the disease or complic	ations that caused the	death Do not ent	600 L:	ber	cty He	eights E	Balto.,	MD 21207	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death									
	/Medical		disease or condition resulting in death) a. Suppose 3 days Due to (or as a consequence of):									
	Examiner		Sequentially list conditions b.									
	rate be executed only sician and the burial-transit											
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3/60,		cal E	Due to (or as a consequence of):									
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ň	0 0 0									Month Day Year		
J O	requires that the de een signed by the a hould be detached t		9 Unknown	9□ Unknown								
_	igne bed		Part II. Dther significant conditions contr	5	ot resulting in the ur	nderlying caus	e given ir	n Part I.	23e. Did to	bacco use contrib	oute to the cause of death?	
ecords	been si		pulmonary embolism					1 🗆 Y	1 Yes 2 No 3 Probably 4 Unknown			
ည္	e 2 sh	nple	congestive hea	at fail	une				24a. Was a	sy pri	ere autopsy findings available or to completion of cause of	
<u> </u>	iicien: The lav certificate has rector, page 2	ertification: To Be Cor		ral disc	ese				perfor		ath?]Yes 2□ No	
VITAL	Physicien: this certific ral director,		25. Was case referred to medical examiner?	spital: V.			0.1		ath (Check only or			
0	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral dir		1 Yes 2 No		2 ER/Outpatien 28b. Time of			4 Nursing	Home 5 Reside	ence 6 Other		
0			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury			28c. Injury at 28 Work?				,,,,		
IVISION	Attender death	tifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street an building, etc. (Specify) 28f. City or Town, State						reet and Number	or Rural Route Number,		
5	rs after or rel Dii	O	4 Homicae building, etc. (Specify) City or Town, State)									
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my	y knowledge, death mination and/or inv	occurred at the	ne time, o	date and plac	e, and due to the curred at the time, d	ause(s) and mann ate and place, and	ner as stated. d due to the cause(s)	
	o the	Mec	29b. Signature and title of certifier	and manner stated.								
	⊢s⊢ó		V Gan	MN						29d. Date signed (Month, Day, Year)		
	0	1	30. Name and address of person who com	pleted cause of death	(Item 23a) (Type I	Print)	7-0	100	1	Torre	26,0004	
			Shawna Escope	un mor	Sinai	HOOV	oitz-	e of	Balt	imore	26,2004	
	Sta Registra		31. Date filed (Month, Day, Year) APR 9 0 26	32. Registrar's S	Signature	-						
	m 1401316	- 1	AFR 2. 4. //	11111	134.3	35 - M A						

Patient Known As: Robert Buze

		1 - For Amend Item #10d Registrar 1. Decedent's Name (First, Middle, Las		Cerunca	le or Deairi	2. Date of [Death		3. Time of Dec	
Physici /Medi		matte	Broadno	مان		Abril	Da >/	y Yeer	7:2)	
Examir		4a. Fecility Name (If not institution, give	1 -	1	, Town, or Location o	f Death	4c	County of Dee	in /	
		NORTHWES				STOWN		BAL	TIHORE	
Funeral Director		5. Social Security Number 6. Se 131-26-2962 Usual Residence of Decedent	7. Age (In yrs. la	Yrs. Months	r 1 Year If Under 2 Days Hours		Day, Year	30 V	rthplace (State or Fo Juntry) RG/N/	
nous aret deau with the maryand tural', or fleme 23a or 28a-f show al Examinat the multiped at		10a. State 10b. County	10c. City,	, Town or Location					10d. Inside City L	
	ctor	MARYLAND BALT	IMORE	RE	STERST	OWN			1 Xes 2	
	Director	10e. Street and Number	- 10	10f. Zij	Code		10g. Cit	izen of What C	ountry?	
			TERSTOWNK	DAD	2//	36		us	A.	
F F	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No	If Yes, spe	dent of Hispanic Origicity Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Ame Black, Whi		
Evan	ρ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	22 No Specify:			Specify:	1 ACK	
Medic	Completed	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Usu	al Occupation ork done during most	of working	16b. K	ind of Business	:/Industry	
	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT u	se retired)	n 11	<	o	- 0	
Hygien ther th		17. Father's Name (First, Middle, Last)	1 YR	KECOR		RR 's Name (First, Middl		CIAL SUMMEN	LURITY AL	
d d	To Be	ROBERT	MITTO	CHELL		GG-1E	o, maroeri		20205	
th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (T				or Rural Route Num	ber, City o		Zip Code)	
f Heal item 2 other		BULDETTE MAR	7 N-EL (DAUGHTER)	1/11 ~ ^	1. 0 4	VE. BA	TIM	RF. 14	0.2/2	
		20a. Method of Disposition 1-Surial 2-Scremation 3 □		ace of Disposition (Nametery, crematory or	me of	Date	20c. Lo	ocation City or		
nent ant: † ury o		'4 □Donation 5 □Other (Specify,		GMEM. PI	ARK O	5-05-04	Woo	DLAW	W. MARW	
Department Importent: eny injury conce.		21. Signal re of Funeral Service Liotin	" · D	22. Name ar	nd Address of Facility	Ben	111)	TR. FL	INSEAL HE	
2 E e d		- Uni	1 10	374	SN. FUZ	TONAVE	131	7270,1	10212	
hysician /Medical xaminer pnial-trausit		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the death. ne cause on each line.	Do not enter the mod	le of dying, such as o	ardiac or respiratory	arrest,		Approximate Interval Betwee Onset and Dear	
		Immediate Cause (Final disease or condition resulting in death) a. 54/55 5/60 4/60							Cristi and Doa	
			Due to (or as a conseque	ence of):						
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	erfce of):						
	Examiner	cause: Erner U. denlying Cause (Disease or injury that initiated events								
ien a		resulting in death) Last	Due to (or as a conseque							
gned by the attending phy: be detached for use as the	dicai		J							
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No							Date of delivery Month Day Year	
	ciar									
	hysi	9 Unknown	9□ Unknown							
	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of deal			
	ed	1 T Ye						s 2 No 3 Probably 4 White		
	Completed					24a. Was		24b. Were au	topsy findings avai	
pa	Con					perf 1 ☐ Yes	ormed?	death?	2 □ No	
director, pag	Be	25. Was case referred to medical examiner?	lospital:		O++	of Death (Check only				
r this rat dii	-: To	1 Yes 2 10 No 1 Planatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 North, Day Year) 1 North Death (Month, Day Year) 1 North Death (Month, Day Year)					g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
m. : After s funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		200. 2000 No. Highly occurred					
ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, street, factory, office 28f. Location					ation (Street and Number or Rural Route Number,		
od in l	Sert	4 Homicide determined building, etc. (Specify)					City or Town, State)			
winin z4 nouls after deam. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation in my only in the cause (s) and manner as stated.								
the F	Medical	one) and manner stated.							to the cause(s)	
CO To	Σ	29b. Signature and title of certifier 29c. License number					29d. Date signed (Month, Day, Year)			
		Alike /15: 11 4377 4 April 81, 2004								
1)			Apple Control of Seath Head of	10-1 (T D.:)	1 /		/	- 1	/	
3	1	30. Name and address of person who co	mpleted cause of death (Item 2	(Type, Print)	- 4	e 1	1 4	C15 74 7	mad Ina	